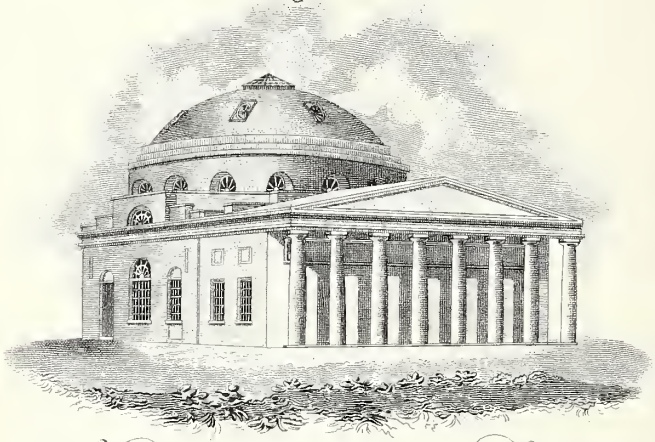
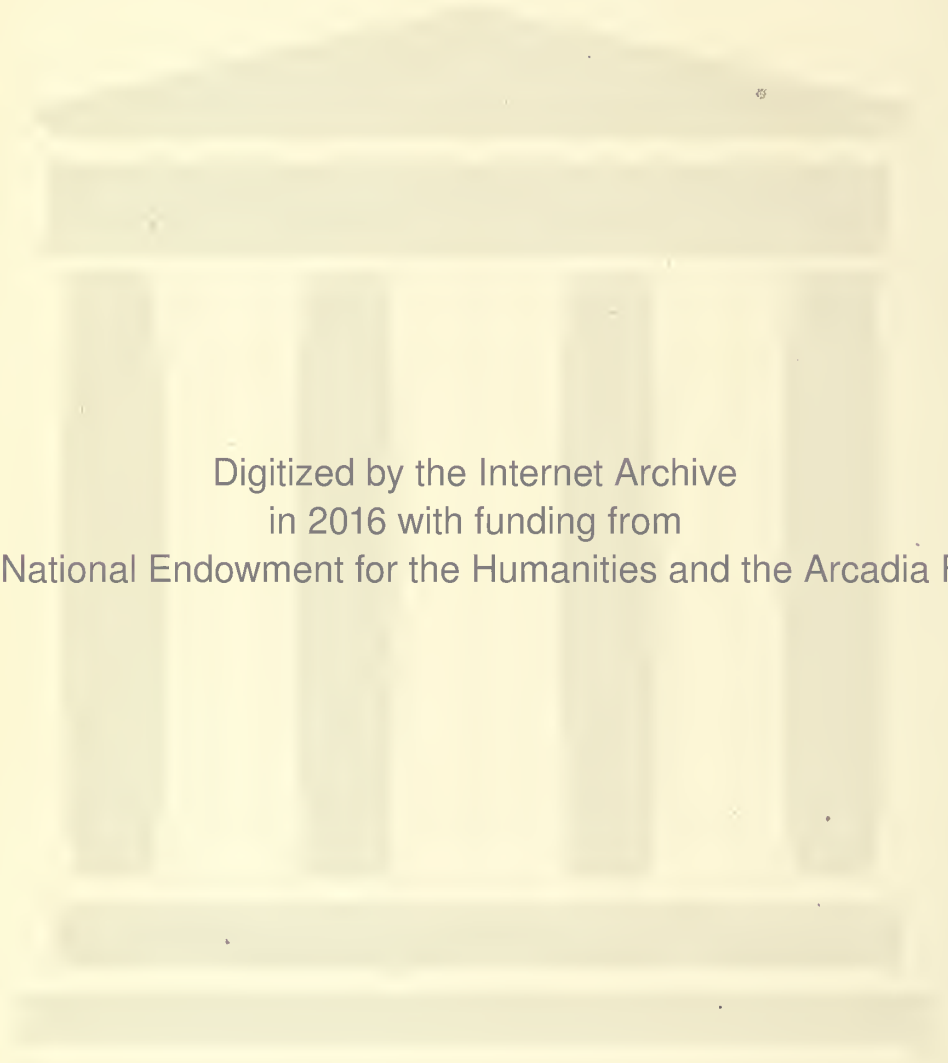
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The OHIO STATE MEDICAL JOURNAL

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THE OHIO STATE MEDICAL ASSOCIATION
AS A MEDIUM OF SERVICE TO ITS MEMBERS

JANUARY 1, 1935 VOL. XXXI Number 1

Best Wishes for the New Year

Council Minutes and Preview of Vital Legislative Issues Among Important News Published in This Issue.

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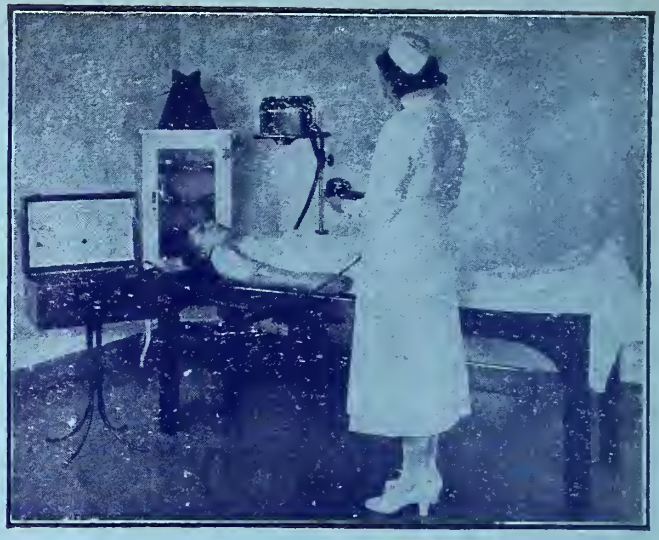
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The Ohio State Medical Association

Ohio State Medical Journal

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Greene	Geo. Davis, Xenia	R. R. McClellan, Xenia	1st Thursday, monthly.
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Hardin	F. M. Elliott, Ada	W. N. Mundy, Forest	3d Thursday, monthly.
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Putnam	W. D. Hickey, Leipsic	W. B. Light, Ottawa	1st Tuesday, monthly.
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Geauga	Lura E. Gordon, Burton	Isa Teed-Cramton, Burton	Last Wed. Apr. to Dec.
Huron	H. H. Ewing, Willard	J. C. Steiner, Willard	Once monthly, Feb., May, Sept. & Dec.
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Holmes	Clyde Bahler, Walnut Creek	C. T. Bahler, Walnut Creek	1st Wed., Feb., Apr., June, Aug., Oct., Dec.
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Summit	R. G. Werner, Akron	A. S. McCormick, Akron	1st Tuesday, monthly.
Wayne	W. A. Fritz, Wooster	R. C. Paul, Wooster	2d Tuesday, monthly.
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Carroll	(With Stark Co. Society)		
Columbiana	F. R. Crowgey, Salem	G. E. Byers, Salem	2d Tuesday, monthly.
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Harrison	A. C. Grove, Jewett	W. C. Wallace, Hopedale	3d Wednesday, monthly.
Jefferson	H. H. Minor, Steubenville	J. Y. Byers, Steubenville	3rd Tuesday, monthly
Monroe	G. W. Steward, Woodsfield	A. R. Burkhart, Woodsfield	2d Wednesday, monthly.
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Athens	W. E. Howe, Nelsonville	T. A. Copeland, Athens	1st Monday, monthly.
Fairfield	L. E. Stenger, Lancaster	C. W. Brown, Lancaster	2d Tuesday, monthly.
Guernsey	C. A. Craig, Cambridge	Reo Swan, Cambridge	1st and 3rd Thursday each month.
Licking	Geo. H. Brown, Hebron	G. A. Gressle, Newark	Last Friday, monthly.
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Muskingum	M. A. Loebell, Zanesville	Beatrice T. Hagen, Zanesville	1st Wednesday, monthly.
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Perry	James Miller, Corning	F. J. Crosbie, New Lexington	3d Monday, monthly.
Washington	W. W. Sauer, Marietta	G. M. James, Marietta	2d Wednesday, monthly.
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Hocking	C. C. Lyon, Logan	M. H. Cherrington, Logan	Monthly.
Jackson	J. S. Hunter, Jackson	J. J. McClung, Jackson	2nd Tuesday, monthly.
Lawrence	Cosper Burton, Ironton	Anne D. Marting, Ironton	1st Thursday, monthly.
Meigs	H. M. Crumley, Pomeroy	R. E. Boice, Middleport	3d Thursday, bi-monthly.
Pike	L. E. Wills, Waverly	R. T. Leever, Waverly	1st Monday, monthly.
Scioto	R. P. Elder, Portsmouth	Wm. E. Scaggs, Portsmouth	2d Monday, monthly.
Vinton	O. S. Cox, McArthur	H. S. James, McArthur	3d Wednesday, monthly.
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Delaware	J. K. James, Delaware	W. E. Borden, Delaware	1st Tuesday, monthly.
Franklin	Verne A. Dodd, Columbus	John H. Mitchell, Columbus	1st four Mondays monthly.
Knox	E. V. Ackerman, Fredericktown	R. L. Eastman, Mt. Vernon	Last Thursday, monthly.
Madison	R. S. Postle, London	G. C. Scheetz, West Jefferson	4th Wednesday, monthly.
Morrow	C. E. Sherman, Cardington	T. Caris, Mt. Gilead	1st Tuesday, monthly.
Pickaway	D. V. Courtright, Circleville	E. R. Austin, Circleville	1st Friday, monthly.
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PUBLIC HEALTH - SOCIAL WELFARE MEDICAL ECONOMICS and ORGANIZATION PROBLEMS

With Editorial Comment by D.K.M.

Concurrent with the advent of the New Year, the medical profession finds the establishment of some system, or systems, of socialized medicine in this country more imminent now than ever before.

Problems of the New Year

Determined efforts to sell the public some form, or forms, of compulsory sickness insurance, or some system of medical service, subsidized and controlled by government, national or state, are increasing in scope and intensity.

The ensuing year will be a stormy one for the medical profession. Present signs point to an impending show-down on what the future method or modes of distributing medical service will be.

Is the medical profession prepared for this crisis?

What immediate steps should be taken to insure the maintenance of efficient and competent medical service for the American people?

This is a problem of nation-wide proportions and importance. Naturally, it must be met by the entire medical profession, with the American Medical Association taking the lead in coordinating medical forces for the critical tests yet to come.

The leaders of the American Medical Association have assumed this responsibility. They are taking the initiative and have formulated courses of action for organized medicine everywhere.

However, little can, or will, be accomplished by the administrative heads of the American Medical Association unless they have the active support of every component unit of organized medicine and every member of medical organization.

There are several obvious weaknesses in the present position of the medical profession which must be corrected before it can wage an effective offensive or defensive campaign.

The correction of these weaknesses is for the most part a matter which has to be undertaken by the individual physician and the local units of medical organization.

First, in spite of the publication repeatedly in this and other medical journals of articles dealing in a comprehensive manner with many phases of socialized medicine, many physicians are not adequately informed on this question, largely because they have been indifferent with respect to reading the material published for their information and benefit.

Many county medical societies and academies of medicine have made too little effort to keep their members in touch with trends and developments affecting medical practice through program presentations and otherwise. Some have shirked responsibility in failing to take an active part in concerted attempts to arouse interest among the profession generally in the social and economic aspects of medical practice.

Until physicians as a group realize the importance of having an intelligent understanding of the involved and acute problems confronting them and until all medical societies realize that they have an important part to play in mobilizing the profession for definite action, the influence of the profession will carry too little weight.

Second, there is a deplorable lack of effective physician-to-public contact on public questions in many communities.

Unfortunately, much of the information the public gets is compiled by lay writers; by social propagandists; or those having their own special interests to serve. Obviously, the bulk of such information is inaccurate or colored.

Innumerable groups such as nursing, pharmacy and dental societies, welfare groups, parent-teacher and student organizations, business associations and clubs, are manifesting an increasing interest in the social aspects of medicine. They are eager for addresses, discussions and conferences on these questions.

It is regrettable that much of the information being presented to the lay public is lacking in medical viewpoint and frequently is from a source definitely committed to schemes and theories in many respects inimical to public health and good medical practice.

The same thing is happening in the journalistic field, as evidenced by the type of material being published in many of the current periodicals.

The medical profession has no desire to have a censorship established. However, it should be interested in seeing that the viewpoints of the medical profession are properly considered.

Every local medical society should devise some method of furnishing informative material, either written or oral, to local groups interested in medico-social problems and encourage them to look to the medical profession for information which

the profession is best able to furnish.

Most physicians are members of or have contacts with civic and social groups. They can make use of these contacts to insure that the proper medical viewpoint prevails in their activities and educational programs.

In the final analysis the public will decide what kind of medical service it wants. For that reason the value of creating a sympathetic understanding of the policies and principles for which the medical profession stands among influential lay groups cannot be over-emphasized.

This is a task which the individual physician and the local medical society must undertake.

Third, it is essential that the local units of medical organization determine the viewpoints of its members toward what changes, if any, should be made in the present system of medical service.

Frank discussions should be held. Consideration should be given the opinions of all members. Attitudes of the majority should be the basis of policies and lines of activity.

The mechanism of local experiments in medical service and their effects on public health and medical practice should be studied to guide future decisions and action.

The foregoing ideas and suggestions are neither unique nor original. They have been emphasized frequently.

They are reiterated for the sake of emphasis and they are accompanied by the hope that they may serve to stimulate greater activity and tend to warn the profession of a few vulnerable spots in its present position.

— OSMJ —

Read and Preserve Journals

This being the season of the year for New Year resolutions we suggest this one for each member of the Ohio State Medical Association:

"I will read each issue of *The Ohio State Medical Journal* during the ensuing year and preserve each carefully so that I may have a permanent file for 1935."

As the Publication Committee has emphasized repeatedly to the membership, *The Journal* is a permanent, consecutive and authentic record of the transactions and activities of the State Association. It is the source of much valuable information regarding events and developments directly affecting medical practice, as well as scientific material, useful and valuable to each physician in his everyday practice.

For all practical purposes, *The Journal* is a "newspaper" for the busy physician and should be read by him regularly and analytically. Its value in organization procedure cannot be over-emphasized, especially at this time when it is more vital than ever before that every physician be fully and accurately informed concerning trends and developments involving questions of public health, scientific medicine and medical practice. Frequent analyses of laws, regulations and court decisions affecting medical practice are especially important.

Why each issue of *The Journal* should be preserved is obvious. Frequently in setting forth information on important public questions it is found expedient to refer to reports and articles which have been published by citing previous issues in which such material was published.

Therefore, unless each member has a file of *The Journal* available he will be unable at times to get a coherent picture of some of the questions in which medical organization and the medical profession as a whole are deeply interested.

The Journal serves an indispensable purpose in the activities of organized medicine. For that reason it should be read and preserved. It deserves the support of the membership generally.

It has been noted that a number of county medical societies and academies of medicine refer frequently to articles published in *The Journal* in announcements sent to local members regarding local meeting programs, urging all members to read them.

This method of stimulating reader-interest in *The Journal* is commendable. It should be used by every society which issues bulletins or notices to members.

— OSMJ —

Teamwork Imperative

By the time this issue of *The Journal* reaches the membership, many county societies and academies of medicine will have elected their officers for 1935. The remainder are preparing to do so in the near future.

It is to those members who have been chosen by their colleagues to hold offices of honor and responsibility that these comments are directed.

Every physician elected or appointed to office in his local medical society is justified in considering himself the recipient of a distinct honor.

However, he should make a further analysis of the compliment paid him by his associates.

In the first place he holds their confidence or he would not have been chosen. Therefore, it is encumbent on him to see that this confidence is not violated and that he, by his actions, measures up to the trust bestowed upon him.

Second, he doubtless was selected for the particular office he holds because the majority of his colleagues believed him competent to handle the work of that office and that he would reflect credit upon himself and the society as a whole by the way he carried out the duties assigned to him.

Third, he must possess some of the attributes of leadership or he would not have won the support of his associates. So, it is his duty to show them that he is a leader and one who can be relied upon to take the initiative in organized activity.

The ensuing year will be a crucial test of the strength of organized medicine. For that reason, it must be equipped with real leaders; those who are not afraid to work and work hard, and have the faculty of getting their colleagues to do likewise. Moreover, it must have leaders who are recognized for their sound thinking and unselfish interest in promoting the purposes of medical organization and the welfare of the members of the medical profession.

The officers, and their lieutenants, of a county society cannot and should not be expected to shoulder the entire responsibility of keeping the wheels of the society moving.

However, it is up to them to cut a pattern for the membership to follow and to inspire the entire membership to concerted activity.

Moreover, it is their duty to assist in coordinating the activities of the local society with those of the State Association and its officers and committees.

Each officer of each county society should realize that his society is one of the important links in organized medicine and that one of his responsibilities is to try to have his society function in such a way that it will accelerate, not retard, the activities of organized medicine throughout the state as a whole.

The actual leaders of medical organization are those at the helm in the various communities of the state. It is vital that they discharge their duties to the best of their ability and lead their society in the teamwork so necessary to success in the undertaking of the State Association.

— OSMJ —

Official Health Administration

Elsewhere in this issue of *The Journal* is published an article relative to the annual conference of Ohio health commissioners with the State Department of Health.

The article summarizes some of the highspots of the work which has been performed by official health departments in Ohio during the past year.

The way most of the official health departments have carried on in the face of serious financial problems is a credit to their administrative heads and the state as a whole.

However, the fact remains that these important branches of local government still are "up against it". They need the active and moral support of all individuals and groups interested in the protection and promotion of public health. The medical profession should be among the first to champion the maintenance of sound public health activities and actively support those public health officials who have functioned effectively and properly.

Some observers have pointed out that official health departments in some communities have been unable to do effective work because of the disposition to scatter functions and responsibilities primarily belonging to public health administration among other governmental agencies.

Likewise, it has been said that frequently overemphasis is placed on the activities of voluntary and lay health agencies and too little public support given to the necessary work that can be done only by official health departments.

Dr. Haven Emerson, in his retiring address as president of the American Public Health Association, delivered at the 1934 meeting of the organization at Pasadena, California, made the following pertinent comments on this latter situation:

"It has been my observation that where there is a high quality of professional leadership and reasonably adequate support for the department of health, private health agencies do not multiply or increase in importance. The visiting nurse associations are in my opinion the only volunteer health agencies still indispensable where a community has a well organized health department.

"This leads to the further opinion that if the time, effort, organizing ability, public spirit, and contributions in cash for volunteer health agencies were diverted to the direct and exclusive support and advancement of the health department, almost any community would be better served than at present, with less cost, less confusion, less rivalry for public credit, and more community self-respect.

"Protection of the public health, as distinct from the private practice of preventive medicine, is a highly responsible technical and complicated function properly vested in civil government and trusted to professional trained health officers. In an orderly and mature society the amateur, the volunteer, has no proper place as an agent of public health in a city, county, or other local political unit. * * *

"The good people who support a duplication of governmental functions in health, welfare, and education will do well to attack community needs at the source, and see to it that the health department at least does those things, and does them superlatively well, which philanthropy and executives responsible to volunteer boards can achieve only fractionally under private auspices. * * * The local private health agency has served its once useful purpose, * * * and they should be gently but firmly eased out of the picture while professional official leadership assumes full control of the situation."

Public health administration has established itself in Ohio as a necessary, independent, and component part of local government. It should not be submerged in an extensive welfare system. It should be permitted to stand on its own feet. It deserves adequate financial support for necessary activities. It should be kept elastic so that it can adjust itself to local conditions.

The official health department can be, and is, a potent factor in community advancement if permitted to function without interference and meddling on the part of "amateurs", theorists and re-

formers; if it gives the public the type of service it needs and deserves; if it has the support and cooperation of the medical profession in its undertakings.

To help maintain official public health work in Ohio on a sound and scientific basis and prevent the enactment of crippling or reactionary laws relating to public health should be one of the major objectives of organized medicine during the ensuing year.

The records of Ohio's health departments are in general satisfactory. In some instances, there is need for changes in personnel and for more constructive activity. In many districts, there is an obvious need for a more sympathetic attitude on the part of budgetary and appropriating officials.

Some minor readjustments in the present administrative system may be made to meet changing conditions. However, all proposals of this kind should be considered from the standpoint of whether or not they will enhance administrative procedure and add greater safeguards to the public health.

— OSMJ —

Diet Fads

In all probability, nothing has given the average physician more headaches and done more to counteract his efforts to impress patients with the fact that after all medicine is not a mysterious thing, than the busy-body activities of food and diet faddists and the exploiters of products advertised as possessing omnipotent health-building and health-restoring powers.

Of course, science and scientific application have their place in food and feeding. The physician realizes that. At the same time, he realizes that Dr. Thurman B. Rice, professor of bacteriology and public health, Indiana University, said a mouth-full when he declared:

"Real science makes sense, and if it doesn't make sense it isn't science."

Dr. Rice's pertinent statement concluded an extremely interesting discussion by him in the monthly publication of the National Food Bureau and headed "Scientific Piffle".

The following excerpts from his comments should encourage physicians to continue trying to counteract the effects of "scientific piffle" by advising their patients to use a little common sense in matters of health and forget a lot of the foolish health rules that have been thrown at them in the name of science:

"We once heard a learned professor stand before an audience of eight hundred women and tell them that it is extremely important that their children should get a little copper in their food daily, else they will suffer from anemia", Dr. Rice stated.

"The information was probably good enough but not at all to the point because the children will get the copper without the mothers fussing about it. It is doubtful if fifteen chemists could devise means so that the children wouldn't get the copper, provided they were given a typical American ration. The same speaker insisted that the children have some of the 'pyrrhol ring' every day, too, but didn't tell the mothers where to get it. We looked it up and found that there is nothing to worry about. The children could hardly avoid getting it in abundance. The poor mothers who had assembled to learn how to feed their children went away bewildered. They had learned nothing that would help them fill eager mouths with real food. They lamented the fact that they had never had an opportunity to go to college and get a Ph.D., in chemistry so that they would know how to feed their children, when the chances are ten to one that if they had the degree they wouldn't have children to feed.

"A really noted authority on diet spent an hour and a half telling—in rather technical language—a lay audience what the requirements of a balanced ration are. Then, he ended by saying that all of the various ingredients are abundantly present in the usual diet except three—lime, iodine and vitamine D. Somehow we cannot get very much excited about these three when we remember that lime is abundantly present in milk, vegetables, fruits, bread, cereals, and most of the water we drink; that one can hardly buy any other salt than the iodized brands, and that sunlight—not to mention various fish liver oils, radiated goods, and milk, butter, eggs, and bathroom lights of various sorts—is to be had for the taking. The noted authority didn't say, mind you, that there is much danger of shortage of lime, iodine and vitamin D, but only pointed out that the margin of safety is not wide in the case of these three.

"There is such a thing as being over-accurate. There is no need to call out the standing army when kids in the vacant lot get into a fight over a football, and by the same token there is no need to call out the latest scientific achievements of the chemistry of nutrition when these same kids come in demanding food. Let 'em eat in peace and contentment. Push up a lot of real, plain he-man food and watch it disappear into the great unknown. Forget for the moment about calories, vitamines, alkaline reserve and feed them the good old-fashioned, time tested and proved foods that stick to the ribs—bread, milk, beans, vegetables, fruits, meat, eggs and a little of everything.

"Is it not a fact that every species of animal from the lowest to the highest knows by instinct what it shall eat? Otherwise, that species would long ago have become extinct. Are we to suppose that man is the only animal that doesn't instinctively know about such things? . . . Do you suppose a rabbit ever had a dietetics lesson or that he ever eats a mouthful of food that he doesn't want or like? Yet he is fat enough—never obese—has firm gums, clean, white teeth, is not constipated, and seems to be getting along. How do you suppose a codfish got all of that vitamine D? He didn't get it by taking codliver oil, did he? He got it by living in the open and eating the natural food that he craved.

"It is not that we are opposed to science—indeed not—but only that we are saying that real science makes sense, and if it doesn't make sense it isn't science. There is nothing so inaccurate as over-accuracy, and naught so unscientific as scientific piffle."

ON THE TREATMENT OF TULAREMIA

By LEE FOSHAY, M.D.,

Cincinnati, Ohio

SERUM therapy is the only form of treatment that has been given a sufficiently extended trial to warrant even tentative conclusions. Neoarsphenamine has been recommended but seems to have been little used[1]. The majority of writers say it is inefficacious. I know of a small number of cases in which its use was without beneficial effects; also of a few cases where it seemed to terminate symptoms in the later stages of disease. Immunotransfusions and convalescent serums have been used a few times, often with apparent benefit. The limitations to these forms of treatment are those inherent in the nature and sources of the substances used. Baer has recently shown that the progress of the disease may be arrested in certain patients with primary lesions if the lesions are treated lightly with *X*-rays during the first three or four days of illness[2]. The limitations of opportunity for any extensive repetition of these interesting experiments must be obvious. A few years ago I tried vaccine therapy during the acute febrile stage but found it unsatisfactory for many reasons and soon abandoned it entirely in favor of serum therapy[3].

Working in Dr. Wherry's laboratory, and under his supervision, I made anti-serum in 1930, but did not use it clinically until November, 1931. Since that time all patients who have needed any special therapy have received anti-serum. During the first two years only goat serum was used. These results have already been recorded[4, 5]. Recently, with the aid of O'Neil, we have developed an antitularense horse serum which has been used rather extensively during the past year. The horse serum is equally as potent as the best goat serum, though it has induced more serum sickness.

As soon as it was apparent that the first goat serum was clinically effective, and in order to gain a wider experience with serum therapy than could be had locally, serum has been supplied in average adult therapeutic amounts to physicians who have wanted it for clinical use. In return a complete record comprising accurate quantitative data on each patient's illness was requested. This has extended the experience to include patients from a majority of the United States and from Japan. There are disadvantages to such a plan but I believe they are compensated for by the independent criticisms from widely scattered sources.

So far, 240 patients have received serum therapy. Eight of these were chronic cases, patients who had had continuing signs and symptoms for more than one and one-half years before specific treatment was begun, and will not be included in this report. Ninety patients received goat serum and 150 have received horse serum. Of the 232 serum-treated acute cases records are completed for 188, and these data furnish the basis for this report.

In order to establish an accurate means of comparison I have compiled quantitative data from the records of 138 cases in which no treatment other than symptomatic or expectant was given. These data appear in the first column of the table. The figures show that untreated cases have a mean duration of disease of five and one-fourth months, that the duration of disability is about four months, the duration of adenopathies a trifle over four months; the febrile period lasts for 26 days, the hospitalization period 30 days, and that the incidence of suppurative adenitis in the glandular and ulceroglandular types is 58 per cent. This gives a general picture of untreated tularemia. Comparison of these figures with those from corresponding data from the serum-treated patients, in the second column of the table, shows the favorable changes that have been induced by serum therapy.

Briefly, the noted changes are: the duration of disease has been shortened by 50 per cent, the duration of disability by 50 per cent, the duration of adenopathies by 45 per cent, the duration of fever not significantly altered; the incidence of suppurative adenitis has been lowered to 45 per cent, and the bed-ridden or hospitalization period to 21 days. In this series the incidence of exanthematous lesions was 20 per cent, and the mean duration of primary lesions was 32 days. Serum was administered to these patients from the 1st to the 148th day of illness, the average time of initial injection being the 28th day of disease. Consequently the average results obtained are not as good as they might have been had more patients been treated earlier. For example, the incidence of suppuration of nodes in the 47 patients who were treated on or before the 12th day of disease was only 38 per cent, and the febrile and hospitalization periods were still further shortened to 20 days and 17 days respectively. This reflects the clinical experience with individual patients: the earlier they are treated the better the responses and the shorter the convalescent periods. In my opinion the optimal time for serum therapy is before the 12th day of disease.

If the possibility of tularemic infection is borne

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From the Department of Bacteriology and Hygiene and the Cincinnati General Hospital, University of Cincinnati College of Medicine.

in mind the diagnosis can almost always be verified by this time, for the majority of patients are so ill they early seek medical aid. The intradermal test has become an unusually reliable diagnostic aid[5, 6]. About 300 tests have been performed. With patients in a dying condition the test has failed twice. Within the first six days of illness I know of only four failures. Three occurred in persons over 50 years, from two of which I recovered B. tularense from primary lesions by guinea pig inoculation. In two of the four persons giving false negative responses additional skin tests became positive before the 9th day. In one of the bacteriologically proved cases a positive test was not obtained until agglutinins appeared simultaneously on the 11th day. This represents a very small incidence of failures in proven cases of tularemia; and to date no false positive reactions have been obtained. It is necessary to remember, however, that skin sensitivity, like agglutinins and opsonins, can persist for many years, and a positive test may only betray the occurrence of infection in the remote past. History and examination are indispensable.

The principal therapeutic characteristics of the anti-serum have been described before and will be mentioned only briefly here. There is usually a marked antitoxin-like action, consisting of a pronounced recession of fever, malaise, arthralgias, myalgias and psychic disturbance; usually appearing within three days after administration, and often associated with a marked reduction in the sizes of the enlarged lymph nodes. There follows an acceleration in the healing of primary lesions and also of any previously performed glandular incisions. There is a small but significant decrease in the incidence of suppurative adenitis, the decrease being greater as patients are treated earlier. Serum therapy prevents the establishment of chronic tularemia. During the past four years I have encountered ten patients with continuing signs and symptoms that date back from one and one-half to five years. None of the serum-treated patients has had such experience. Serum therapy also seems to prevent the occurrence of general tularemic sepsis, the only constantly fatal complication. Out of 226 patients who received serum before sepsis had occurred there were no deaths. Five of the six deaths in the total series occurred in patients who were clearly septic before serum was given, showing continuous high fever, profound psychic disturbances, diarrhea, enlarging livers and spleens, rapidly progressing pneumonic lesions and in some instances signs of meningeal involvement. The other death occurred on the 47th day of disease with questionable indications of sepsis. The patient had extensive severe arteriolar disease, involving especially the heart and kidneys, and it is unlikely that he could have survived any severe infection.

Bronchitis and bronchopneumonia have occurred frequently; pneumonia appearing in 32 patients, often associated with wet or dry pleurisies. Although it is true that most patients who die from tularemia have pulmonary lesions at death[7], it seems to be uncommon for a patient to die of tularemic pneumonia unassociated with general bacterial invasion that occurs some days before death, and differing from the usual terminal septicemia in the sense in which we usually use that term. I hope to collect enough data eventually to elaborate further this distinction, which I believe to be valid. It is shown by the work of Blackford and his associates[8] that tularemic pneumonia has a much greater incidence than the highest case fatality rate yet assigned to the disease. The majority of these patients do not die. In the serum-treated pneumonic cases there were no deaths. The tentative conclusion reached is that tularemic pneumonia by itself is not often a cause of death, and that with serum therapy to help out there is no mortality from such pneumonias.

The serum has been given most frequently by vein, in doses of 30.0 cc. per patient, usually in 15.0 cc. amounts on two successive days. This dosage is still recommended for cases of average severity. A few patients will need 60.0 cc. of serum, but not many. Much larger amounts have been given but I cannot see that they have added anything useful beyond what the recommended maximum of 60.0 cc. would have done. Children under 14 rarely need more than 15.0 cc., and subcutaneous or intramuscular injections are wholly satisfactory. I do not expect to have the last word on proper dosage. As with other serums much will have to be left to individual clinical judgment, time, and experience; yet I would warn now of a growing tendency to give too much rather than too little serum. The patient who really needs large amounts is the one with tularemic sepsis, but unless it is given in large quantity at the very onset of sepsis I doubt if many such deaths will be prevented.

Goat serum induced serum sickness in 42 per cent of cases, and by far the majority of instances were short and mild. Horse serum has caused a 63 per cent incidence of this disturbance and a much greater number were severe and prolonged. This is often a real misfortune, for in many cases there seems to be something inherent in the reaction of serum sickness that nullifies the therapeutic activity of the serum. I have not time to cite examples of this but there have been many, and perhaps some of you have also observed this.

Besides stimulating specific phagocytosis the serum exerts a specific desensitizing action, in that positive skin tests with the standard suspension often cannot be obtained after serum has been given. This applies to tests performed three days

COMPARATIVE DATA FROM PATIENTS WITH TULAREMIA

Duration of:	Control; Untreated	Serum-treated All patients	Serum-treated; 12th day or before
Disease (Mos.)	5.25± 0.18	2.78± 0.08	2.42± 0.16
Disability (Mos.)	(Av.) 4.0	2.12± 0.06	1.76± 0.12
Adenopathies (Mos.)	4.11± 0.19	2.41± 0.09	2.32± 0.18
Fever (Days)	26.76± 0.75	26.44± 0.88	20.33± 0.93
Hospitalization (Days)	(Av.) 30.0	21.47± 0.91	17.50± 1.11
Primary lesion (Days)	No data	32.10± 0.92	24.52± 1.30
Suppurative adenitis; Incidence	58%	45%	38%
Exanthem incidence	No data	20%	—
Initial serum injection; Average day of disease	—	28	8
Mode	—	15.1	9.8
Mortality	6 to 8%	2.5%	0

SHOWING THE DIFFERENCE, WITH THEIR RESPECTIVE PROBABLE ERRORS, BETWEEN THE MEANS AS INDICATED

Duration of:	Control cases compared with:			
	All treated cases		Cases treated 12th day or earlier	
	Difference	Difference P. E. Diff.	Difference	Difference P. E. Diff.
Disease	2.47± 0.20	12.2	2.83± 0.24	11.6
Adenopathies	1.70± 0.21	8.1	1.78± 0.26	6.8
Fever	None	—	6.43± 1.20	5.4

Except where indicated all differences are significant. The odds against such deviations being due to chance alone are greater than 1,500 to 1.

and ten days after the last dose of serum. A study of the variations of these test responses indicates that they are useful in predicting the outcome of adenitis. Summarized in brief, my data show that positive tests after serum indicate a necrosing lesion, usually in a node of course, and that the numerical chances for eventual suppuration of some node are at least two to one. If tests after serum are entirely negative the chances against any nodal suppuration at any future time are at least twenty to one. Further observations are needed to establish their exact reliabilities.

Special treatment of lymphadenitis includes hot Mag. Sulph. solution dressings, and simple incision if, and only when it is certain, suppuration has occurred.

Primary lesions are necrosing ones, not suppurative, and should not be incised. The most satisfactory dressing for ulcerated primary lesions that I know is a wet dressing of half-saturated commercial urea, first suggested to me by Dr. John Foulger[9]. If this causes pain, and occasionally it does, a weaker solution should be used. Ulcers remain clean and free from secondary infection when so treated, and heal more rapidly. A recent criticism of Millar's use of urea crystals in controlling the fetor of infected sloughing superficial cancers[10], stated that urea was not antiseptic. However, using concentrations recommended by Foulger, it is readily demonstrable that half-saturated urea kills many common pathogens, also B. tularense[11].

Although lymphangitis seldom appears in uncomplicated infections, and requires no special treatment, I have evidence of its frequent inapparent existence. During convalescence many patients have complained of inability to abduct an arm to normal degree, and examination has shown one or more thin tough subdermal cords, often with scattered nodules like a knotted string, extending upward from near a primary lesion site and always terminating in the center of a lymph node. When these healed lymphangitic cords end in axillary nodes elevation of the arm stretches them taut and painless complete abduction is actually prevented. I have seen this disability misinterpreted as a residual arthritis. The restriction seldom lasts for more than three weeks.

In closing, serum therapy is of real value. The one disadvantage is the likelihood of serum sickness, and I hope something can be done to lessen it. Although three or four patients were not greatly improved, mainly in the earlier period when smaller doses were being used, I know of no instance of a completely bland response. There can be no doubt that it has greatly shortened the course of disease and the distressing and costly long period of disability, and little doubt that a number of deaths have been prevented.

126 WELLINGTON PLACE.

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DISCUSSION

WALTER M. SIMPSON, M.D., Dayton: Professor William B. Wherry, of the University of Cincinnati, was the first investigator to recognize tularemia as a disease of man. In September, 1914, Wherry, and B. H. Lamb, his then student as-

sistant, described the occurrence of the disease in a patient of Derrick T. Vail, ophthalmologist, at Cincinnati. In a paper published in October, 1914, Vail stated that "the case presented such unique, alarming and peculiar ocular symptoms that it was impossible from anything written in ophthalmic literature to render a clinical diagnosis." Vail enlisted the aid of Wherry, who inoculated a guinea pig with scrapings from the conjunctiva. The guinea pig died in six days; autopsy revealed whitish foci of necrosis in the spleen and liver. After repeated animal passages of the virus, Wherry became acquainted with the work of McCoy and Chapin in the recovery of *Bacterium tularense* from the ground squirrels of Tulare County, California, and succeeded in isolating the same organism on coagulated hens' egg-yolk mediums. Wherry's animal experimentation included the inoculation of 49 guinea pigs, three Belgian hares, three white rats, three kittens and one pigeon. The oculoglandular form of the disease was reproduced in guinea pigs and rabbits. In a paper describing the clinical characteristics of the first recognized case of *Bacterium tularense* infection in a human being, Vail pays Wherry this splendid tribute: "I have to thank Professor William B. Wherry . . . for the diagnosis. Without his splendid, accurate and convincing laboratory work, this case would have passed into oblivion, unrecognized and undiagnosed."

Wherry and Lamb next isolated *Bacterium tularense* from two wild cottontail rabbits found dead in southern Indiana. They issued the first warning (J.A.M.A., Dec. 5, 1914) that the cottontail rabbit is the important reservoir of infection for man.

In 1915 and 1917, respectively, R. Sattler and F. W. Lamb, also ophthalmologists of Cincinnati, described similar cases of "conjunctivitis tularensis," a name introduced by Lamb. Both of these patients had dressed wild rabbits just prior to the development of the disease; Wherry again isolated the organism from the tissues of guinea pigs which had been inoculated with scrapings from the conjunctival lesions.

Now we have further evidence of the importance of Wherry's pioneer endeavors. Foshay, working in Wherry's laboratory, has devoted four years to the development of a potent anti-*tularense* serum. We have used Foshay's anti-*tularense* goat or horse serum in 10 cases of tularemia. Compared with over 100 cases of untreated tularemia observed in and about Dayton, the prompt and favorable influence upon the fever and adenopathy left little doubt as to the efficacy and specificity of the treatment. The best results were obtained when two injections, each of 15 cc., were given on successive days. Serum sickness occurred in five instances. We have found the Foshay diagnostic skin test to be a simple and reliable method of attaining an accurate diagnosis during the first week or ten days of the disease, before serum agglutinins develop. It is apparent that the establishment of early diagnosis by the skin test method and the prompt administration of anti*tularense* serum, preferably during the first twelve days of illness, will exert a distinctly favorable influence on the morbidity and mortality of this disease. It is to be hoped that the skin-test suspension and the antiserum will be generally available through the usual trade sources in the near future.

THE STILLBORN

By WALTER W. BRAND, M.D.,

TOLEDO, OHIO

ONE of the most difficult problems with which we have to contend, in conducting a woman through her pregnancy and labor, are the traditions and superstitutions which have been handed down from primitive peoples generation after generation. The folklore of all races is burdened with erroneous and dangerous advice and practices. Even in the early period of the twentieth century, we frequently have to contend with these primitive superstitions and practices. Notable is the continuance of an inadequate, unsupervised and untrained midwife service.

"Obstetrics is the Cinderella of Medicine, and is even now beginning to ascend into a proper position amongst the sister branches. This fortunate turn of events is due to the realization, tardy enough, that obstetrics is one of the greatest of all branches of preventive medicine. The prevention of fetal death is one of the chief aims of the preventive side of obstetrics". (Holland).

In the United States there are 150,000 infants either stillborn or die shortly after birth. One death every three minutes. "According to Edgar A. Doll, it is estimated that 1 per cent of the total population of the United States is mentally deranged. This indicated that there are approximately 1,250,000 mentally deficient individuals in this country, 10 per cent according to the author or 125,000 it is claimed are due to birth injury". (Bland).

The White House Conference reported that 1,000,000 children have defective speech, 1,000,000 with weak or damaged hearts, 3,000,000 have impaired hearing, 18,000 are totally deaf, 300,000 are crippled, 50,000 are partially blind, 14,000 are wholly blind.

What percentage of these deaths and deficiencies could have been prevented we do not know, but it seems to me that we can conservatively estimate 50 per cent as preventable, if our present day obstetric knowledge could be universally and skillfully applied. Obstetricians and general practitioners cannot accomplish much alone. We need

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the support and cooperation of nurses, social agencies, welfare organizations, hospitals and public health agencies to bring to the attention of the laity the advantages of ante-partum supervision, and intra-partum care of the pregnant woman.

Adair-Holland and Lane-Claypon have published tables of a large series of stillborn infants in which they show that approximately 50 per cent of the deaths are in the intra-partum period —20 per cent in the ante-partum period, 3.6 per cent prematurity, and the balance in maternal-placental, fetal states and causes unknown. "From an analysis of these figures it would seem that half or thereabouts of all the fetal deaths are the result of faulty obstetrics, while one-fourth are due to curable diseases of the mother, leaving but one-fourth as preventable. This brief statement is surely an index of the improvement which must come in the general practice of the obstetrical art". (Curtis).

The Advisory Committee of the Children's Bureau (Publication No. 223 on Maternal Mortality in Fifteen States) comments on maternal care, as follows:

"This section shows clearly what a serious situation exists in regard to the quality of the maternal care that many women receive in this country during their pregnancy. Although this study covered but fifteen (15) states, they represent a fair cross section of the country, and therefore it is probably fair to assume that the findings in this section are applicable to the country as a whole.

"Fifty-four (54) per cent had no ante-partum examination by a physician. In only 1 per cent, was the care given up to the standard that it is the right of every pregnant patient to have and demand".

Of the 54 per cent who had no ante-partum care, the attending physician can not be held responsible, for he was not consulted. There appears to be a relationship between the grade of ante-partum care and the percentage of live births. Those patients who received Grade 1 and 2 care had 70 per cent of live births, 63 per cent for Grade 3 care, and 58 per cent for those who had no care. We can assume from these statistics that about three-fourths of the 20 per cent of still births in the ante-partum period could have been prevented, with efficient ante-partum examination and care. As was previously stated 50 per cent of fetal deaths occurred in the intra-partum period, from complications of labor (including ante-partum hemorrhage) and of these stillbirths, one-half were due to intra-cranial hemorrhage. In breech deliveries 88 per cent died of intra-cranial hemorrhage and in placenta previa, 50 per cent of the fetuses were stillborn.

Again we must assume that a large percentage of the intra-partum deaths were preventable. Ante-partum care, as has been said, is the "strategy", and intra-partum care the "tactics" of obstetrics. Ante-partum care of the pregnant woman "the strategy" has been exploited by governmental and social agencies, so at the present time, in our larger cities and in some of the smaller, there are fully equipped and efficiently conducted ante-partum clinics in our hospitals and more and more pregnant women are availing themselves of this service. But it seems to me the "strategy" has been exploited and the "tactics" almost forgotten. The medical profession has been sluggish in its leadership. We should be the leaders, not some social welfare organization. Obstetricians and the general practitioners who practice obstetrics, have not been alert and alive to preventive methods as have the leaders in other fields of medicine. It is for the leaders in obstetrics to work out the solution of problems in our special field. One of our greatest problems is, not only to educate and re-educate ourselves, but also the general public, to the advantages of good attention during pregnancy and labor.

In 1909 ante-partum work was begun in New York by the Association for the Improvement of the Condition of the Poor. In the spring of 1909 the Women's Municipal League of Boston became active. These two social movements were the beginning of ante-partum work in the United States. Later in 1909 the American Association for the Study and Prevention of Infant Mortality was formed and in 1923 united with the Child Health Organization of America and became the American Child Health Association.

In 1912 the Children's Bureau of the Department of Labor was created by Congress. In 1918 the Maternity Center Association in New York City was organized. In 1921 Sheppard-Towner Act became a law, and in 1925 the Joint Committee on Maternal Welfare of the American Gynecological Society, the American Association of Obstetricians and Gynecologists, the American Child Health Association and the Section of Obstetrics and Gynecology of the American Medical Association was formed.

From the activities of these organizations ante-partum clinics were established in our metropolitan areas. "With development of ante-partum care, it was discovered that very few physicians took the trouble to go over carefully with the patient, the care that she should take of herself during this important period of her life. The busy general practitioners had little time and many had not the inclination to go into the details that careful ante-partum care demands, and, in fact, few realized what such care meant". (De Normandie).

In consequence, in ratio to the national population, a very small percentage of our pregnant women could avail themselves of this service. A small group of obstetricians in Cleveland, obstetrically conscious and from personal observation,

feel justified in saying "practical idealists" began to scrutinize and analyze the maternal and infant mortality in the Cleveland hospitals. With the tabulation of their findings valuable information was disclosed and practically applied, resulting in a lowering of the hospital mortality rate. The "news" of their activities spread and a few obstetricians from adjacent cities were invited to attend their meetings. We were intriged not alone by the scientific side but also by the spirit of friendliness and fellowship between the individual members laboring in a common cause, "Making Motherhood Safe".

From this group there was born a statewide organization in December of 1933 "The Hospital Obstetric Society of Ohio", organized in hospital units of three groups according to the number of deliveries in a year. This society is continuing the Cleveland study in the state, which is divided in six districts. In the constitution of this society, Article 2 reads: "It shall be the purpose of this society to develop better methods for the hospitalization and care of the obstetrical patient and the newborn child. To this end it is our purpose to study all the conditions which affect the welfare of patients who enter hospitals for obstetrical care and to introduce and standardize methods for the improvement of the care of such patients". It seems to me that the purpose of this society is a monumental, forward movement, in obstetric practice.

The value and importance of ante-partum care of the pregnant woman is so clearly and concisely set forth in the pamphlet of the Children's Bureau of the Department of Labor, entitled "Standards of Pre-natal Care; An Outline for the Use of Physicians", that comment at this time is unnecessary. As 50 per cent of stillbirth occurs in the intra-partum period, it seems to me, some discussion of the more frequent complications of this period is pertinent at this time.

PLACENTA PREVIA

In establishing the cause of fetal death we should determine if it was the result of obstetrical treatment or a pre-delivery death from natural causes of this condition. In treatment of such a case, it is important to know if the fetal heart can be heard, if not, unless complicated by hemorrhage, leave the patient alone, she will deliver in a short time. If a fetal heart is heard except in the central type, rupture of the membranes usually will suffice. If central previa with or without disproportion, an immediate Cesarean Section is indicated. Always be prepared for transfusion, either before or after delivery as condition of patient indicates. If fetal death occurs during delivery it is often due to a too rapid delivery of the vertex if forceps are used, or too great traction with rapid extraction of head in breech cases.

Intra-cranial hemorrhage occurs usually from too rapid delivery of the head, rapid compression followed by sudden expansion. We must be deliberate and deliver gently as well as slowly the after coming head—we must remember the fragility of the fetal head. Where there is a rigid perineum and vulvar ring, careful ironing out as taught us by Potter. If that procedure is unsuccessful or contra-indicated, episiotomy. It is surprising the ease with which the after coming head is delivered where outlet rigidity has been overcome.

There is no cause for hurry, 12 or 15 minutes in breech extraction can be safely allowed from the time the umbilicus is at the vulva. The Piper forceps, correctly applied, is a valuable aid if there is difficulty in extraction. If we are careful and avoid over treatment, we will be more successful in the conduct of such cases.

CONTRACTED PELVIS

If recognized in the ante-partum period—and it should be—contracted pelvis rarely leads to fetal death. A comprehensive pelvic mensuration and cephalometry either by actual measurement or *X*-ray should be done on every case. If in doubt the performance of Mueller's manouver under anesthesia, to accurately determine the possibility of delivery from below, is a safeguard.

In our hospital practice it is unfortunately too true that we frequently see cases of pelvic contraction, that have, and have not had medical supervision until actually in labor, and sometimes cases that in previous pregnancies resulted in stillbirth. With a slight degree of pelvic contraction and a small vertex, women can pass through labor successfully but in subsequent pregnancies, we may have a larger vertex, resulting in sacrifice of the fetus by neglecting pelvic and fetal mensuration. In contracted pelvis, in the absence of disproportion, delivery by forceps is indicated, early not late. By that I mean, complete dilatation with retraction and paralysis of cervix, with good uterine contractions, vertex not progressing. Correct application of forceps, traction in axis of pelvis with not too great traction. It seems to me, there are more intracranial hemorrhages in cases of posterior position and transverse arrest where the vertex is pounded hour after hour until the patient is exhausted, than there are in skillful forceps deliveries. As a rule forceps operation is performed late and of course the forceps operation is credited with the cause of death. There should be a very small incidence of fetal death with Grade 1 ante-partum care and with obstetric skill and judgment in the intra-partum period.

CESAREAN SECTION

With the exception of retroplacental hemorrhage, placenta previa, late toxemia of pregnancy in primipara, uterine inertia and uterine atony, we should know if Cesarean Section is indicated at the 36th or 37th week of gestation, provided our

ante-partum examination and observation has been comprehensive and complete. If a section is necessary for other conditions, than before mentioned, the attending physician is subject to just and honest criticism. Cesarean Section is an obstetric operation and should be performed by obstetricians, not general surgeons. It seems to me the contraindications are just as and sometimes more important than the indications, if the welfare of the mother is considered. General surgeons can perform a technically perfect operation but are not endowed with obstetric judgment or skill, in other words, the tactics, in determining in the interest of the mother, if a pubiotomy, embryotomy or craniotomy is the operation indicated. An operative delivery is a surgical procedure and should not be undertaken by physicians untrained in the technique of obstetric surgery.

In conclusion I wish to urge every obstetrician and general practitioner who practices the obsetric art, to use all his powers of persuasion to obtain an autopsy on every stillborn fetus, including the umbilical cord and placenta. The findings will be of inestimable value to all of us. If fetal death was inevitable, from congenital malformation, fetal pneumonia, anaerosis, from cord complications, concealed hemorrhage, ablatio or placental insufficiency, we should know. If preventable, was the application of intra-partum methods, the factor, we should want to know, so that we can perfect our technique and avoid subsequent tragedies. We must be sincere in our desire to lower the fetal mortality rate in our state and do our part by cooperating with the Hospital Obstetric Society of Ohio in its idealistic goal, to make our state "Safe for Motherhood".

217 COLTON BUILDING.

DISCUSSION

DR. A. J. SKEEL, M.D., Cleveland: Obstetrics is, as Dr. Brand says, preventive medicine. We try to prevent the occurrence of injuries, morbidity and death, as end results of reproduction.

The figures show 15,000 puerperal deaths and 150,000 infant deaths annually. Infant mortality is ten times as great as maternal mortality. Dr. Brand's paper is therefore timely, since unquestionably many of these deaths are preventable. Many of the mentally deficient are in this condition, because of birth injuries. Some, but not all, of these injuries are preventable.

I must beg to differ from Dr. Brand, if he means by the statements in his paper, that one half of the million children with defective speech, of the three million with impaired hearing, of the million with defective hearts, etc., could have been prevented by better obstetrics, unless he wishes to classify sterilization of the unfit, as part of the field of obstetrics. Perhaps in the broader sense it is so. I agree that one-half of the fetal deaths are preventable with perfect obstetric care. We must remember, however, that all too frequently the procedure designed to save the baby from injury or death, carries some additional risk to the mother. Hence the increase in the number of Cesarean sections, for which obstetricians have been criticized, not always justly.

As to the tremendous importance of more and better prenatal care, which Dr. Brand so forcibly urges, there can be no question. Both fetal and maternal death rates are amazingly diminished by such prophylaxis. Two factors are at work in producing the astonishing figures published: (First) The prevention of pathological complications, or their early treatment, is clearly of prime importance. (Second) The doctor who gives his patient excellent prenatal care, is probably a pretty good obstetrician, whether he be general practitioner or obstetric specialist.

We endorse heartily every word Dr. Brand has said about better care for patients with placenta previa or contracted pelvis. Maternal and fetal lives are daily being sacrificed because of late diagnosis and ill chosen treatment of these cases.

We know too little of the cause of many fetal deaths, and I am sorry to say, frequently the post mortem does not enlighten us. This subject needs intensive study at every opportunity. We need to learn how to prevent placenta previa, hydramnios with its fetal deformities. We need to learn how to grow normal pelves.

However, we have for too long been dabbling here and there, trying to remedy weak spots in obstetric practice without going to the heart of the matter, viz., major deficiencies in obstetric teaching. The general practitioner does the bulk of obstetric practice. The surveys of mortalities, have laid the greater portion of them at his door. But whatever his deficiencies may be, they are the fault of our system, and not of his neglect or lack of ambition.

A system which licenses a man to practice obstetrics, after he has delivered only ten to twenty-five women; a system which does this, and then practically bars him from further improvement in the obsetric art, except what he can get by his own reading and experience, is responsible for most of our preventable deaths, both fetal and maternal.

Medical school teaching is deficient not in quality but in quantity. Teachers of obstetrics have for years pleaded almost in vain for more time and more material. Public demand for better care is slowly changing this condition, but this change can only help the next generation, not the present.

The second count in the indictment, is against those of us who have charge of large obstetric clinics, and have not opened wide the way, for our next door neighbor in general practice to keep abreast of modern obstetric thought and technique. Here a change can be made at once, and its results will be immediately felt.

It can be done in this way: (First) Hospitalize every patient possible; (Second) Let every hospital organize the general practitioners, desiring to bring their patients to such hospital for delivery, into a compact group, to be known as the affiliate obstetric staff. This affiliate group should agree to staff supervision and control of the private patient, and to attendance on the obstetric conferences and clinics. The child as well as the mother, gets the benefit of skilled supervision. The doctor has in effect a continuous post-graduate course.

Recognize these men as especially desirable by giving them increased hospital facilities, such as limited ward privileges. Publish their names in the annual hospital report.

Since our organization at St. Luke's, giving the chief authority to intervene in the patient's behalf, went into effect some months ago, I have not once

had to advise one of these men to consult a specialist. They have beaten me to it, and take pride in doing so. Every man among them is a better obstetrician, as the result of his attendance on the staff conferences and clinics. I think none of them would sacrifice his newly found opportunities without vigorous protest. Early diagnosis is aided by this increased training.

I believe Dr. Brand was before us, in completing a correct staff organization. It was he who came from Toledo to our Cleveland Hospital Obstetric Society meetings, and proposed a state-wide organization of similar type.

I congratulate him on his timely paper, and on what he is personally doing to promote better obstetrics.

SCOTT C. RUNNELS, M.D., Cleveland: One point of view expressed both by the essayist and Dr. Skeel in his opening discussion perhaps needs further emphasis, and that is the necessity for cooperation in the study of problems of infant and maternal mortality. The medical profession has a tendency to err in the direction of each of its members trying to play a lone hand in their own practice.

The correction of infant mortality and the education of the laity as well as the profession itself can only properly be accomplished through cooperative means. Hospital staffs and the obstetrically minded profession in any locality need the cooperative stimulus of such groups as described by Dr. Brand and Dr. Skeel. We must all sink our individualities for the good of the whole. I wish to commend the essayist for a most timely and exhaustive study of infant mortality and to compliment Dr. Skeel on the success of the work which he has been so instrumental in organizing.

G. MOMBACH, M.D., Cincinnati: There are a few points that Doctor Brand brought out with which I do not absolutely agree. I am of the opinion that a Cesarean Section should be performed in placenta praevia in all primiparas. I am, however, fully in agreement with his treatment of this condition in multiparas.

Doctor Brand metnioned Potter's method of ironing out the perineum. I prefer to do an episiotomy. While it is perfectly true that one can iron out the pelvic floor so as not to get a tear on delivery; one may, nevertheless, be very apt to produce an overstretching of the muscular and fascial layers, and later one would find a relaxed vaginal outlet. This is in accordance with a law in physics which is known as the law of the limits of elasticity. It is for this reason that I believe that an episiotomy should be done in all primiparas.

I fully agree with Doctor Brand that the prophylactic forceps operation is far better than forceps applied late in labor. I also believe that the child's head does not stand the beating produced by a long, hard labor very well. Many newborn children have a tendency to be bleeders; and after a prolonged labor or a difficult forceps operation, one may find intercranial hemorrhage in these cases of hemorrhagic disease of the newborn. I have, therefore, made it a practice to inject some of the father's blood intra-gluteally into these babies immediately after delivery.

I also agree with Doctor Brand in what he said about Cesarean sections done by general surgeons. I have made this same remark on many occasions and feel that only the qualified obstetrician is the man to do a Cesarean section.

STRANGULATED HERNIA: FACTORS INFLUENCING MORTALITY

By A. TALBERT BOWERS, M.D.,

DAYTON, OHIO

IT should be of the utmost interest to every physician to know the hazards associated with strangulated hernias. An appreciation of these dangers is of importance in gauging the prognosis of a patient before instituting treatment. There are few conditions which require such exercise of judgment and skill. A proper understanding of the seriousness of strangulated hernia will ordinarily prompt the physician to advise operation, particularly in patients with incarcerated hernias or hernias which are difficult to reduce.

With this purpose of evaluating the factors which contribute to a successful or unsuccessful outcome, I have selected cases from the public services at the Miami Valley Hospital, Dayton, Ohio. Such patients are frequently admitted in a serious condition, largely as the result of delayed hospitalization. A series of fifty-four consecutive cases was selected over a period of nine years and three months, from January, 1924, to May, 1933. The patients ranged from three months to eighty-three years in age. Eight patients gave a history of primary hernia with the immediate development of strangulation, while in forty-six patients secondary hernia had existed from one week to twenty years.

The average age for the entire group was 49.94 years; the majority of the patients were in the fifth to the eighth decade. It is interesting to note that five occurred in the first decade, while two of the patients were over eighty years of age. The mortality in this series was closely related to the age grouping, as will be shown subsequently.

There is ordinarily no excuse for delay in diagnosis. The symptoms are definite and almost stereotyped. The pain is generally sudden in onset and is always located in the region of the bulging and strangulation. The absence or disappearance of pain indicates some pathological

change of the contents, such as gangrene of the bowel or infarction due to thrombosis of the vessels leading to the strangulated contents. The localized pain is soon followed by generalized abdominal pain, cramp-like in nature, and occurring in spasms if a loop of intestines is caught in the mass. Nausea, followed by vomiting, was present in most of our cases of over twelve hours' duration. The character, frequency, and amount of vomiting depended upon the location of the obstruction and the duration of the strangulation. Vomiting develops rapidly in strangulation of the small bowel, while it may be absent for a considerable period in strangulation of the large intestine. The pulse rate is ordinarily uninfluenced during the first twelve to twenty-four hours, but gradually increases after that time. Generally speaking, the older the patient the more likelihood of a slow pulse and subnormal temperature. The majority of the patients have normal or slightly subnormal temperature. Elevation of temperature means the intervention of complications, such as gangrene, peritonitis, rupture of the bowel, or pneumonia.

Physical examination in the region of the hernia reveals a firm, tense, elastic, irreducible mass. The overlying tissue is generally elastic and freely movable. Rarely is the external tissue discolored. Coughing does not give an impulse in the hernia sac. In the case of inguinal hernias the mass may be so small that it is barely palpable or the mass may fill the entire scrotum or labia. In the early stage the abdomen is generally soft. Later, when intestinal obstruction occurs or peritonitis intervenes, the abdomen becomes distended and rigid.

The diagnosis of strangulated hernia calls for immediate surgery. The only contraindication to surgery is a moribund patient. Attempts to reduce the mass by taxis are extremely dangerous as there is always the possibility of rupturing the intestine. Gentle reduction of the mass by external means should be attempted only if there is no evidence of strangulation. The delay caused by futile attempts at external reduction of the strangulated hernia constitutes one of the important factors in a disastrous outcome.

The type of anesthesia to be used depends largely upon the patient's condition. The patient who has been vomiting should be given a local anesthesia by local injection or subarachnoid infiltration. In young patients, who are given general anesthesia, aspiration of the gastric contents should precede the anesthesia. In the older patients local injection provides the greatest margin of safety. While it seems probable that the danger of inhalation pneumonia has been exaggerated, every precaution should be observed in dealing with this class of patients.

The pathological picture of the strangulated bowel can be roughly divided into three classes: those in which congestion is present, those in which there is inflammation, and finally those in which there is a frank necrosis and gangrene. In the first group, after relieving the strangulation, the circulation rapidly returns and the intestine assumes a normal color. Pulsation in the mesenteric arteries and the arterioles can be readily palpated with return of circulation. The mucosa is smooth, moist, and shiny and peristalsis is present. Viability of the intestinal wall of this group is assured and there should be no hesitancy in replacing the intestines. If, however, the circulation is sluggish in returning, the serosa is dull, and the peristalsis is absent or slight, viability of the intestine is questionable.

The ability of nature to revitalize damaged intestine is remarkable and in those cases showing no actual necrosis or thrombosis of the mesenteric vessels, the bowel generally recovers its normal structure and function. In five of our cases in which bowel resection was carried out, an end-to-end anastomosis with Murphy button was performed successfully. In only one case was a gangrenous loop of bowel exteriorized and an enterostomy done. This case ended fatally on the twenty-third postoperative day from Bacillus coli peritonitis and terminal bronchopneumonia. Exteriorizing the bowel or delayed resection of the intestine should be reserved for desperate cases. Anastomosis of the intestine by Murphy button can be performed in less time than an enterostomy. It eliminates additional surgery in patients which are already in a critical condition.

MORTALITY

The mortality in a large majority of our cases was caused by unnecessary delay of open operative treatment. In thirty patients, with strangulation of less than twenty-four hours' duration, a mortality of 10 per cent occurred. In eight patients, upon whom operation was performed after twenty-four to forty-eight hours of strangulation, the mortality was 37.5 per cent, an increase of 375 per cent in the mortality rate. Speed in diagnosis and treatment of strangulated hernias is of prime importance to the patient. This is particularly true of patients past sixty years of age, whose vitality is often at a low ebb.

Resection of the bowel was deemed necessary in five cases (9 per cent) with a mortality rate of 40 per cent. From a study of the causes of death, it was found that intestinal obstruction is the most important. In all of our cases in which bowel resection was performed, death was attributed to intestinal obstruction. No matter what type of treatment was used in these cases the outcome would have been the same. Of the two cases which ended fatally, the bowel obstruction had existed for two days in one instance, while in the other the intestine had been strangulated for three days. In the three cases in which

recovery occurred, the obstruction had been present nine hours or less.

The temperature of the patient before operation gives us some clue as to the outcome. Peritonitis, necrosis of the bowel, and pneumonia are the most common causes of fever in this class of patients. The mortality varies directly with the rise in temperature. Forty-six per cent of the patients had elevated temperature before operation. In this group 70 per cent of the deaths occurred. The death rate was doubled among those patients with temperature up to 100° F. over those with a subnormal to a normal temperature.

The types of hernia had a definite bearing on the mortality rate. Femoral hernias are generally smaller and give more difficulty in diagnosis. Strangulation of the bowel in this type of hernia leads to an earlier obstruction and necrosis of the bowel. Of five of our patients operated upon for femoral hernias, four died; a mortality rate of 80 per cent. One patient died on the eleventh postoperative day of pneumonia. Of the remaining three cases the strangulation had existed two days or longer. An exteriorization of a gangrenous bowel was carried out in one case while in another a resection of a loop of small bowel was performed.

The vitality of patients past middle age is reduced and this class of patients must meet surgical intervention with lowered recuperative powers. Every safeguard should be offered these patients. The mortality rate after the sixth decade shows a decided increase, with an average death rate of 33.3 per cent as compared to 18.5 per cent for the entire series. Ten deaths occurred in the fifty-four patients operated upon. For patients under sixty years of age the average death rate was 9 per cent.

CONCLUSIONS

(1) The average mortality rate of patients with strangulated hernias of over twenty-four hours' duration is 41.6 per cent as compared to 10 per cent in patients with strangulation of less than twenty-four hours' duration.

(2) Patients with subnormal to normal temperatures before operation had a mortality rate of 10 per cent as compared to 24 per cent in patients with an elevated temperature.

(3) For patients under 60 years of age the average mortality rate was 9 per cent as compared to 33.3 per cent for patients over 60 years of age.

(4) The average mortality rate of patients with strangulated inguinal hernias was 11 per cent as compared to 56 per cent for all other types of strangulated hernias.

(5) The mortality from strangulated hernias could be greatly reduced if the diagnosis were made promptly, if valuable time were not lost by futile efforts to reduce the hernia by external pressure, and if the open operation could be performed promptly after the diagnosis is made. The loss of twenty-four hours increases the likelihood of a fatal outcome by four times.

201 SOUTH MAIN STREET.

Note: The author is greatly indebted to the following physicians, E. R. Arn, R. C. Austin, R. K. Finley, H. H. Herman, H. R. Huston, and C. S. Smith for the permission to incorporate their cases from the public surgical services at the Miami Valley Hospital, Dayton, Ohio.

TWO FATAL CONTACT CASES OF ACUTE INFECTION OF THE NERVOUS SYSTEM

By JOSEPH L. FETTERMAN, M.A., M.D.,

CLEVELAND, OHIO

INTRODUCTION

The growing interest in the various types of encephalitis and in the problems which have arisen with regards to the changing forms of the acute infections of the nervous system, prompt this report of two contact cases occurring in the same family, both ending fatally.

The excellent historical review contained in the first volume of "Epidemic Encephalitis", published by the Matheson Commission[1], mentions the occurrence of sporadic cases in the past, but stresses the fact that the major epidemic began in central Europe sometime in 1915 and 1916. A wave of encephalitis spread almost throughout the world, reaching a peak of some seven thousand cases in 1920. According to the statistics of the League of Nations, there was a gradual decline until 1924, during which year, again some seven thousand cases were reported. By far the largest number of cases came from Japan. After several years of relative freedom, another severe outbreak occurred in Japan in 1929[2].

Strauss and Rabiner[3] discuss a group of acute infections of the nervous system which occurred in New York City in 1926. These authors quote Flatau who reported an outbreak in Poland in 1928. The case histories mentioned by Flatau

From the Neuropsychiatric Clinic, Lakeside Hospital, Cleveland, Ohio.
Read at meeting of Cleveland Neurological Society, Jan. 10, 1934.

were of the type belonging to disseminated inflammations of the nervous system.

Other local outbreaks have been reported in Indianapolis in 1929 and 1930 by Kempf[4], and in Cincinnati in 1932; and more recently in St. Louis. The epidemic in St. Louis which occurred in the summer of 1933, was highly virulent. According to Leake[5], the patients in St. Louis showed a similarity both clinically and pathologically to those of the epidemic in Japan.

The second wave of encephalitis differed in certain respects from the first or the lethargic type. Those cases which occurred around the Inland Sea of Japan, showed widespread lesions of the central nervous system; the mortality was high (around 60 per cent). The sequelae, thus far, have been psychic with little or no Parkinsonism. This epidemic has been labeled Encephalitis B in distinction to the Encephalitis A of 1917 to 1920.

In Cleveland, we have had no epidemic, yet numerous cases of a more subacute form were recently reported by Karnosh and Stout[6], under the heading of "Acute Disseminated Encephalomyelitis." These authors reported 28 cases of widespread involvement of the central nervous system, subacute in character followed by chronic changes particularly in the spinal cord. The subacute neurologic manifestations in some of their cases resembled acute sclerosis.

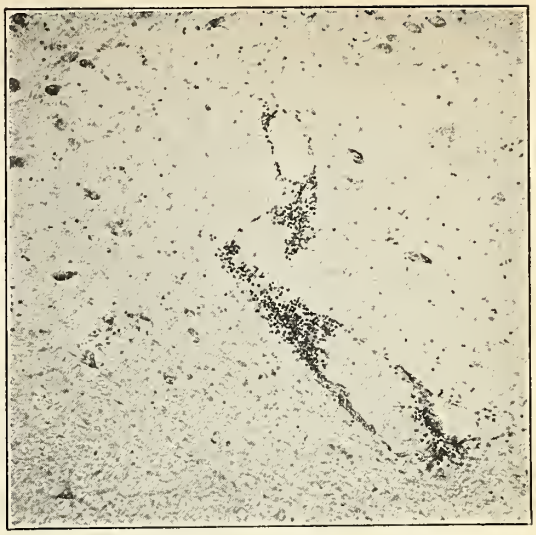


Figure 1

Nisel X 150.

Section through Medulla showing perivascular infiltration and tissue infiltration.



Figure 2

H.E. X 150.

Another section through Medulla showing marked engorgement of all blood vessels, tissue infiltration and small hemorrhage.

CASE REPORTS

Case No. 1, E. P.; age 17, occupation—student; nephew and residing in the same home as Case No. 2. The past history was essentially negative. The onset of illness was at the end of August, 1933, after a two weeks' stay at the World's Fair in Chicago. When E. P. had been in Cleveland but a few days, he complained of lassitude, anorexia and constipation. On September 1, he noticed weakness and then total inability to swallow. Any attempt to take food caused choking. This inability to swallow continued for several days.

On September 8, patient was admitted to Huron Road Hospital by his attending physician, Dr. H. K. Begg, presenting at this time a temperature of 102, leucocytosis of 18,000 and the leading symptoms of difficulty in swallowing.

The outstanding neurologic signs were: pupils of normal size, react well to light and on accommodation; facial muscles symmetrical; hearing and speech normal. *There was complete paralysis of the levators of the soft palate and of the pharyngeal constrictors.* Both vocal cords were in mid-position, causing dysphonia. There was also paresis of the sterno-mastoid muscles bilaterally, making it difficult for the patient to raise his head. The musculature of the arms and legs was somewhat hypotonic. Tendon reflexes were diminished. There were no signs of pyramidal tract involvement, no Hoffman or Babinski. In addition to the paralysis of the throat musculature, the only other observation of importance was frequent jerking movements involving the trunk and lower extremities. They were more violent than choreiform movements. The sensory examination was negative. The spinal fluid was clear with normal pressure, with two plus pandy, and a cell count of 52, chiefly lymphocytes.

The course of the illness from the time of admission was rapidly downward. The pulse became faster, temperature arose to 105 despite the use of tube feeding, intravenous saline and glucose and rectal feeding. The patient became worse and died on September 9, 1933.

A post-mortem examination was done shortly after death by the hospital pathologist, Dr. Goodsit and special neuropathologic stains were followed through by Dr. Sidney Gross.

The autopsy disclosed little or no involvement in structures outside of the central nervous system.

Dr. Goodsit reported that on neurological examination, the dura mater was somewhat injected. There was moderate increase in cerebro-spinal

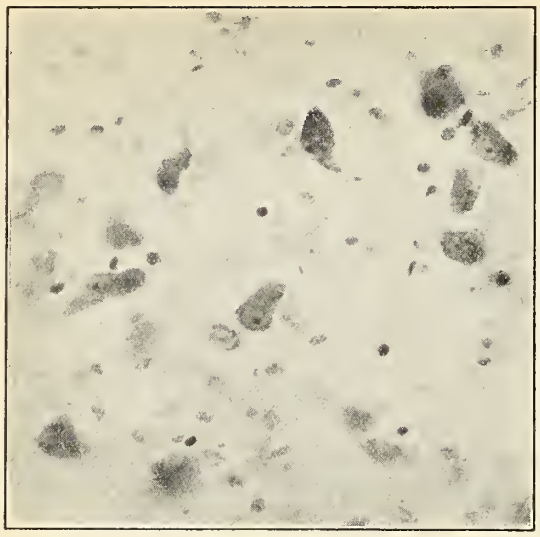


Figure 3

Nisel X 700.

High power of section in Medulla close to area pictured in photomicrograph No. 2. This shows acute ganglion cell changes with loss of cell contour and loss of Nissl substance.



Figure 4

X 1.

Section through middle of pons showing two larger and many punctate hemorrhages.

fluid, especially at the base of the brain. The surface of the brain showed marked dilatation and congestion of the cortical vessels. Examination of the spinal cord shows the superfical dural vessels injected and on section of the cord, the gray "H" is darker red than average and the entire cord appears injected.

Microscopic studies with various stains were made. A section taken from the motor cortex shows numerous, large neuron cells of the motor type with no apparent abnormalities.

Sections taken from the basal ganglia, show engorgement of vessels but no perivascular cellular reaction.

Sections from the upper pons show little change However, a section taken from the lower pons presented a striking picture with large areas of hemorrhage and round cell infiltration. There is perivascular cuffing with round cells, large areas of inflammatory reaction. The motor cells in this section were few in number and show degenerative changes with neuronophagy in places. Sections stained by Nissl method show early and late degenerative changes, with chromatolysis and loss of Nissl substance. (Figures 1, 2 and 3).

Spinal cord: Sections at different level show a similar picture of round cell infiltration and degeneration in motor cells.

The pathologic diagnosis made by Drs. Goodsit and Gross, was acute anterior poliomyelitis.

Case No. 2, M.B.; age 50, married, American, occupation—salesman. M. B. is the uncle of case No. 1, and helped to nurse the young man in the first few days of his illness.

P. H. is negative. The present illness began insidiously about October 15, or about a little over 35 days after the last contact with the younger patient. The first symptoms were headache and pains in the neck, and what patient described as the "first signs of a cold." Later there was a buzzing sensation in the head. Within a week there developed diplopia. Upon my initial examination on October 27, I found the patient comfortable, mentally alert and emotionally normal. The cranial nerve examination revealed a weakness of the left abducens. All other cranial nerves were negative. The neuromuscular system was elsewhere negative except for slight ataxia of the left lower extremity. The patient was hospitalized. Lumbar puncture done—the fluid unfortunately was bloody (trauma). In the course of the following two weeks, M. B. improved considerably. The diplopia disappeared and the left abducens palsy cleared. The headache became milder. The noisy buzzing had faded.

However, after this interval of improvement, the headaches returned, growing more and more intense. They were chiefly frontal in location. At this time, there was slight nystagmus. The abdominal reflexes were diminished. The L. P. showed normal pressure, a plus-minus pandy, six cells. Gradually the patient became drowsy, mentally confused, with peculiar paraphasic speech, and with loss of bladder control. On the following day, he was stuporous and showed right pupil larger than left and bilateral Babinski. On November 27, there was deep coma, respiratory difficulty and then death. (The clinical diagnosis of encephalitis was concurred in by Dr. C. W. Stone.)

It is interesting that the clinical course presented a period of acute onset of symptoms, a remission, and then a phase of greater intensity, ending in death.

Postmortem examination was performed at the Institute of Pathology of Western Reserve University two hours after the death by Dr. D. J. Rehbock.

The significant pathological findings were confined to the central nervous system.

The brain weighed 1350 grams and there was clotted and unclotted blood in both the subarachnoid and subdural spaces. There was greater evidence of organization and more extensive hemorrhage in the subarachnoid space and the pia was generally light brown in color. There was marked hyperemia of the pial vessels and some flattening of convolutions. There was a compression cone of the cerebellum and the pons appeared flattened and widened. On section, there were several small areas of hemorrhage in the pons, the largest of which measured approximately 0.5 x 1 cm. in its cross sectional surface. This hemorrhage extended completely through the pons from the right



Figure 5

X-110.

Section to include the ependyma of the floor of the fourth ventricle stained by hemotoxylin and eosin The photograph was taken with a Wrattan A filter to permit sharper distinction between extravasated erythrocytes and lymphocytes. All of the deeply staining cells around blood vessels represent lymphocytes. To the left of the picture there is an area of hemorrhage and degeneration of brain substance.

cerebral peduncle down into the medulla. (See Figure No. 4.)

Microscopic examination disclosed the most significant changes to be in the pons. (Figure No. 5.) Here there was extensive and advanced degeneration of neurons and in addition to the hemorrhages described grossly there was widespread perivascular infiltration by lymphocytes. In some regions there was considerable depigmentation of erythrocytes and in such areas there was liquefaction of brain substance and infiltration by compound granule cells. Sections of basal ganglia and cerebral cortex were similar in that there was marked edema and some evidence of neuron degeneration. Sections including the pia arachnoid disclosed a diffuse but sparse infiltration by lymphocytes in addition to extensive hemorrhage.

The pathological diagnosis was: Acute hemorrhagic (non-suppurative) encephalitis.

COMMENT

The two cases which are presented offer several interesting problems with regards to contagion and with regards to classification. The occurrence of two fatal cases of acute infection of the central nervous system, in the same family, may have been but a coincidence. Yet, one cannot ignore the element of contact, the similarity in the clinical course and in the fatal outcome and in the major pathologic findings. Contact infection is a possibility.

The exact classification is another problem of interest. From the etiologic standpoint, little can be said because there were no bacteriologic studies made. Furthermore, as the Matheson Commission states, the causative agent has not yet been definitely demonstrated.

The majority opinion favors a virus perhaps activated by an acute infection.

Clinically, in the boy's case, the dominant features belong to that of bulbar poliomyelitis. However, the many involuntary jerking movements of the head, trunk and extremities resembling a very active chorea would indicate a severe involvement of the basal ganglia. It may be remarked at this point, that Faber[7], in a splendid monograph on poliomyelitis proposed the view that the disease starts in the hypothalamus after invasion through the olefactory membrane. From hypothalamus it extends by axonal spread along spinothalamic tract to the cord and then enters the anterior horn cells. The virus of polio has a special vulnerability for these cells.

The infection of the other patient resembles encephalitis. This case is interesting in that it showed a changing tempo of infection, a mild onset, a long period of apparent recovery followed by a state of rapid involvement ending fatally. Faber considers such a course as common

in poliomyelitis in which illness the period of improvement is called "halting".

From a pathologic standpoint, E. P. presented a rather typical picture of anterior poliomyelitis. Whereas, M. B.'s case was that of a hemorrhagic encephalitis. The hemorrhages were noted to resemble somewhat the pathologic cases reported by Muckinfuss and McCordock[8] in St. Louis and also the findings of Broun in the same epidemic. The hemorrhages in M. B.'s case likewise recalled one of the remarks made by McIntyre of Cincinnati who said that in some of his material, on first glance, the diagnosis appears to be cerebral hemorrhage.

If the matter of contact were significant, we may infer that two distinct infections, a bulbar poliomyelitis and an encephalitis are due to the same causative agent. Of course, the anterior horn cell change is common to both these illnesses. It is my own belief that the two cases belong to the encephalitis B group which was epidemic in St. Louis in 1933. Yet, it is more conservative to report them as two fatal cases of acute infection of the nervous system.

SUMMARY

Two cases are presented with a history of contact with involvement of the central nervous system. The symptoms of the first patient resembled poliomyelitis; the other appeared to belong to the group of acute encephalitis. Both ended fatally. Autopsy findings show a similarity in the form of widespread hemorrhagic areas, chiefly in the pons.

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10515 CARNEGIE AVENUE.

SUBCUTANEOUS FAT NECROSIS OF THE NEWBORN

By G. SHONG, M.D., DULUTH, MINN.
and
A. COWAN, M.D., COLUMBUS, OHIO

THERE still exists, in the literature, considerable confusion in the description and classification of the types of induration in the newborn.

Fox[1] has recently reported a series of five such cases, and in an excellent discussion of the subject does much to clarify the haziness of these newborn indurations. We feel grateful to him for his review of the subject, and we shall quote freely from his article.

Subcutaneous fat necrosis of the newborn is a benign self-limited disease, affecting various parts of the body, often symmetrically, leaving exempt, the palms, soles, axillae, abdomen, and inner aspects of the thighs. The lesions appear as deep-seated indurated areas in the subcutaneous tissue. Their size varies, from that of a pea to a hen's egg or even larger, so that much of the back, arms, or buttocks may be covered. Seen early, the color is a dusky red, surface smooth, painless, and feels very hard to the touch. The lesion does not pit on pressure, and its borders are well defined. In attempting to pinch such an area, it is characteristic that the skin cannot be folded.

The usual sites involved are the back, cheeks, arms, thighs, and buttocks. Lesions may be present at birth, or appear within the first three weeks of life. The infants attacked are usually well nourished.

The etiology of the disease has not been established. The most important factors are probably (1) trauma, either during delivery or during resuscitation, (2) exposure of the newborn to cold.

Histology—This condition is confined to the subcutaneous tissue, and consists of a necrosis of the fat cells, plus an infiltration with giant and epithelioid cells. The epidermis and corium remain free. With healing, there is a complete return to the normal structure, with new fat production.

Prognosis and course.—The outcome is always excellent, and the infants remain in good general health throughout the illness. There are no typical symptoms. Softening and absorption of the involved areas gradually take place and become complete within three to four months, after which they disappear as a rule, entirely. In rare instances slight evidences of atrophy may follow.

Differential diagnosis.—(1) Sclerema neona-

torum occurs in debilitated undernourished infants, during the first few weeks of life, or later, in babies who have suffered from severe illnesses. The lesions here begin in the lower extremities, and progress upward rapidly. The skin is cold, white, and waxy, and the temperature subnormal. The prognosis is generally a fatal one. The histological section shows no fat necrosis or infiltration. Feldstein[2] has recently reported a case with recovery.

(2) Sclerema edematosum is rare. It begins from the second to the fourth day of life, and occurs usually in twins, or weak prematures. It starts as an edematous swelling of the dorsum of the feet, calves, thighs, mons veneris, upper extremities and the eyelids. The color may be reddish when seen early, later, a yellowish color due to jaundice. The temperature may be subnormal. Duration is about four or five days with a fatal ending generally, although mild cases recover. The lesions are never sharply circumscribed or isolated, and they pit on pressure. Histology shows edema and inflammation in the skin, subcutaneous tissue, and sometimes the muscle.

(3) Scleroderma is very rare and shows a generalized fibrosis which includes internal organs. In the microscopic picture, the lesion is seen to be in the cutis, with no abnormal change in the fatty tissue.

(4) Erysipelas.—This is attended by fever, severe constitutional symptoms, and the course and prognosis differ greatly as a rule from the fat necrosis cases.

Case.—D. F., female, was admitted to Milwaukee Children's Hospital on March 12th, 1932, with a provisional diagnosis of erysipelas, at the age of three weeks.

The infant was very well nourished, and had a temperature of 101 (R) on the admission date, which lasted for about 24 hours.

The positive findings were limited to the skin. The skin over both deltoid regions and between the scapulae was dusky red, indurated, and giving almost a woody sensation to touch. The hardened areas were well demarcated over the arms, but more confluent over the back. The skin could not be picked up in folds, and was not apparently painful.

The birth history was essentially normal, with the exception that a strip of adhesive had been present on the interscapular region for the first ten days of life. The parents noted the color and induration at the sixteenth day of life. The infant had always taken its feedings well and seemed happy.

Patient was seen for the first time on March 21st, by Dr. A. B. Schwartz, who made the correct diagnosis. Lesions continued to spread slowly, involving most of the extensor aspects of both arms, and a large part of the upper back.

A biopsy was done on March 28th, and the pathological report by Dr. M. G. Peterman is as follows: "Epidermis is normal. The subcutaneous trabeculae are infiltrated with lymphocytes and giant cells, some trabeculae greatly thickened and replacing the fat. Diagnosis—subcutaneous fat necrosis of the newborn."

The course in the hospital was uneventful, the infant thriving well, remaining afebrile and symptomless. She was discharged to the Out-Patient Department on April 2, 1932.

The dispensary note of July 6, 1932, indicated that there was only very slight evidence of induration in the skin of the arm.

Summary.—A case of subcutaneous fat necrosis of the newborn with a brief description of the disease has been described.

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The writer is indebted to Dr. A. B. Schwartz for his permission to report this case.

1293 LIVINGSTON AVENUE.

—OSMJ—

Committeemen For A.M.A. Exhibits

Exhibit committees have been appointed by the 15 sections of the Scientific Assembly of the American Medical Asociation to assist in the promotion of section exhibits at the next annual session at Atlantic City June 10-14. Chairmen of the section exhibit committees are: Practice of Medicine, Dr. Irving S. Wright, New York; Surgery, General and Abdominal, Dr. Alton Ochsner, New Orleans; Obstetrics, Gynecology and Abominal Surgery, Dr. H. C. Hesseltine, Chicago; Ophthalmology, Dr. Georgiana Dvorak-Theobald, Oak Park, Illinois; Laryngology, Otology and Rhinology, Dr. William V. Mullin, Cleveland; Pediatrics, Dr. F. Thomas Mitchell, Memphis; Pharmacology and Therapeutics, Dr. C. D. Leake, San Francisco; Pathology and Physiology, Dr. Frank W. Hartman, Detroit; Nervous and Mental Diseases, Dr. Groves B. Smith, Godfrey, Illinois; Dermatology and Syphilology, Dr. Fred W. Weidman, Philadelphia; Preventive and Industrial Medicine and Public Health, Dr. Paul A. Davis, Akron; Urology, Dr. Russell S. Ferguson, New York; Orthopedic Surgery, Dr. Paul N. Jepson, Philadelphia; Gastro-Enterology and Proctology, Dr. A. H. Aaron, Buffalo; Radiology, Dr. S. W. Donaldson, Ann Arbor, Michigan.

Application blanks for space in the Scientific Exhibit may be obtained from any of the foregoing chairmen or from the Director, Scientific Exhibit, 535 North Dearborn Street, Chicago.

—OSMJ—

The Central Neuropsychiatric Hospital Association held its annual meeting recently in Cincinnati in conjunction with a meeting of the Central Neuropsychiatric Association. The hospital group is composed of 28 sanitaria of the Middle States. A special meeting will be held January 25 at Chicago, at which papers will be presented dealing with private hospital problems and related medical subjects. Dr. D. A. Johnston, Cincinnati, is secretary-treasurer of the former association.

The President's Page

A Personal Communication to the Membership from

JOHN A. CALDWELL, M.D., *President*, Cincinnati, Ohio

The advent of a New Year offers your President an opportunity to express to all members of the Ohio State Medical Association his sincere hope that the happiness and well-being of each member will be enhanced during the ensuing year.

However, in extending to all of you the season's greetings, I must remind you again that present signs indicate the year 1935 will be a crucial test of the courage, patience and strength of the medical profession.

In a certain sense, the future of the medical profession is in the "lap of the gods". We as an organized profession may or may not be able, or permitted, to work out our own destiny. Nevertheless, we must focus our attention on the first alternative. We dare not let it be said in retrospect that we made no effort to meet definite issues now before us or that we offered only a half-hearted defense of our rights and convictions.

It is sufficient to say that we cannot hope to cope with definite problems confronting us, the implications and possible effects of which are well-known to all of us, *unless* we pull together, utilize our potential strength, and through medical organization carry on aggressive, concerted activities in the interests of scientific medicine, public health and the profession, individually and collectively.

As pointed out on the President's Page appearing in the December issue of *The Journal*, it is vital that every eligible physician in the state be mobilized for important responsibilities which will confront us during the ensung months. This can be accomplished by maintaining the membership rolls of every county medical society and academy of medicine at their greatest possible numerical strength and by undertaking programs and activities which will stimulate an active interest in medical organization among all affiliates.

It is hoped that every member will help to usher in the New Year in an appropriate manner by renewing his membership in his local medical society and the State Association and that all eligible physicians who have not been affiliated with medical organization will realize the vital importance of such membership and promptly take steps to secure it.

* * *

It goes without saying that every physician in Ohio should be greatly concerned in the approaching regular session of the Ohio General Assembly.

Recent trends and developments in legislation and governmental procedure, and the general spirit of the times, have caused those in close touch with activities transpiring at Columbus, preliminary to the opening of the Legislature, to be apprehensive and feel that the medical profesison must take a more active interest in legislative and administrative questions during the ensuing months than ever before.

It is not possible for me to go into detail regarding the many important issues having public health and medical aspects which will arise as the Legislature convenes. Our Committee on Public Policy and state headquarters office are in close touch with developments; will keep the membership informed, and will correlate our activities throughout the state on questions as they arise.

However, neither the Committee on Public Policy or the headquarters office, and for that matter the officers and Council of the State Association, can, or should be expected to, assume the entire responsibility for familiarizing the members of the Legislature with the proper medical viewpoint on public questions. This important function is primarily that of physicians in every community of the state—the physician friends and acquaintances of members of the General Assembly, their family physicians, the officers of the county societies, and the legislative committeemen.

The legislative committeemen of the respective county medical societies and academies of medicine are the key-men in this work. They are the contact men between the Committee on Public Policy and the Membership of their local medical society. It is their duty to interview and confer with members of the Legislature or arrange to have other physicians do so; stimulate interest in legislative matters among their colleagues; and keep the Committee on Public Policy and the headquarters office promptly informed on the attitude of their local legislator, or legislators, and on other local developments.

The position of legislative committeeman, especially at this time, is one of primary importance. Some committeemen have indicated by their activities that they will measure up to the responsibilities entrusted to them. Some have not. The membership of each county society should insist that their legislative committeeman take an active, sincere interest in the task he has undertaken. Needless to say whether our legislative activities will succeed or fail will depend largely on how well each local committeeman functions and the type of activity carried on locally.

COUNCIL ACTS ON NUMEROUS SUBJECTS OF IMPORTANCE AT LAST MEETING IN 1934

MINUTES

THE Council of the Ohio State Medical Association met in the headquarters office, 1005 Hartman Theatre Building, Columbus, Sunday, December 16, 1934.

The officers, Councilors, committee chairmen and others present were: President, Dr. Caldwell; President-elect, Dr. Hendershott; Treasurer, Dr. Beer; Councilors, Drs. Smith, Huston, Klotz, Hein, Jenkins, Davidson, Kirkland, Brush, Seiler and Goodman; Dr. Upham, chairman, and Dr. Alcorn, Dr. Platter and Dr. Stone, members, Policy Committee; Dr. Rogers, chairman, Publication Committee; Dr. Southard, State Director of Health; Executive Secretary Martin, and Assistant Executive Secretary Nelson.

The minutes of the Council meetings held during the Annual Meeting, October 3, 4, 5 and 6, 1934 (pages 753 to 755, inclusive, of the November, 1934, issue of *The Journal*) were read, and on *motion* by Dr. Seiler, seconded by Dr. Klotz and *carried*, were *approved*.

1935 ANNUAL MEETING

Dr. Caldwell, President, announced the appointment of the following Council Program Committee for the 1935 Annual Meeting.

Dr. Parke G. Smith, chairman, Cincinnati
Dr. C. L. Cummer, Cleveland
Dr. R. R. Hendershott, Tiffin

There was referred to the Program Committee for consideration a number of suggestions, including a communication from Dr. Cummer to Dr. Caldwell under date of October 18, 1934, containing observations on the last Annual Meeting and suggestions for the set-up and schedule of Section meetings.

Based on a request from the Hospital Obstetric Society of Ohio and communications and petitions from individuals and groups of members, on *motion* by Dr. Smith, seconded by Dr. Goodman and *carried*, the Council authorized the Council Program Committee to create for the next Annual Meeting a separate Section on Obstetrics and Gynecology. By similar action, the Council left with the Program Committee the question of the proposed creation of a separate Section on Pediatrics and other specialties, as provided under the broad terms of Chapter III of the By-Laws as amended in 1932.

TIME AND PLACE FOR 1935 MEETING

Based on the action of the House of Delegates at the last meeting in deciding to hold the 1935 Annual Meeting in Cincinnati, Dr. Smith, chairman of the Council Program Committee, recommended that the Annual Meeting be held the week of October 6 on dates between October 8 and 12. On *motion* by Dr. Jenkins, seconded by Dr. Huston and *carried*, the Council authorized the Program Committee to set the dates for the meeting during the dates recommended.

On *motion* by Dr. Davidson, seconded by Dr. Seiler and carried, the Council instructed the Program Committee to confer with the Council Committee on Arrangements and provide a two and one-half or three-day meeting.

Dr. Smith submitted suggestions on possible arrangement for some of the General Sessions, including the House of Delegates.

President Caldwell appointed the following Council Committee on Arrangements for the 1935 Annual Meeting:

Dr. Parke G. Smith, chairman, Cincinnati
Dr. E. M. Huston, Dayton
Dr. I. P. Seiler, Piketon.

AUDITING AND APPROPRIATION COMMITTEE

In accordance with the constitutional provision for the appointment of a Council Committee on Auditing and Appropriations, Dr. Caldwell, the President, announced the following committee personnel:

Dr. B. J. Hein, chairman, Toledo
Dr. H. S. Davidson, Akron
Dr. A. A. Jenkins, Cleveland.

PROBLEMS OF POLICY, LEGISLATION AND GOVERNMENTAL ADMINISTRATION

On behalf of the Policy Committee, Dr. Upham reported on prospective recommendations by the Governor's Commission on Reorganization of County Government, based on the constitutional amendment adopted in 1933 empowering the Legislature to provide for alternate types of county set-ups, combination of various county functions and other rearrangements to promote governmental efficiency. Special analysis was made by Dr. Upham of the section of the Governor's commission's report on local public health administration. He emphasized that it would be the purpose of his committee in any legislation introduced to attempt to preserve a separate identity of local health administration and to secure adequate financial support for such administration.

Dr. Upham also analyzed a bill proposed by the Ohio Hospital Association to revise and clarify the laws pertaining to the rendering of medical and surgical care and hospital service to the poor, to transfer the administration of such functions from the township trustees and other poor relief authorities to local health authorities. He also reported on a conference by the Policy Committee

with the Legislative Committee of the Ohio Hospital Association, following which his committee submitted certain recommendations for changes in the proposed bill in case it is to be introduced.

Among the principles set forth by the Policy Committee in this connection are: (a) Maintenance of free choice by the needy patient of his own physician; (b) Definite provision for payment to physicians for medical service rendered to the needy (who are unable to pay their own fees), whether such service is rendered in the home, office or hospital; (c) The proposal should *not* contain any definite stipulated fee schedule, but provision should be made for the payment of "reasonable fees" upon authorization by the local health commissioner or the local board of health; (d) In order to insure the practicability and workability of the proposal, the committee feels that there should be inserted in the bill definite provisions for insuring adequate budgetary allowance for health administration to supervise and administer the enlarged functions of local health administration in relation to medical and hospital care of the needy; (e) Definite provision that *all* health commissioners must be physicians in good standing in their profession. The committee feels that this should be done especially in view of the enlarged duties and responsibiilties of health commissioners directly in connection with medical administration, as contemplated in the bill. While the committee favored a general provision to authorize the State Director of Health or the Public Health Council of the State Departmennt of Health to establish minimum standards for health commissioners, it is not believed that such requirements should include special courses in public health, as relatively few physicians or health commissioners have had such courses. Moreover, some physicians in general practice who have administrative ability and experience would be splendidly qualified for health commissioners even though they had not had special academic courses in administration.

On *motion* by Dr. Davidson, *seconded* by Dr. Klotz and carried, the Council *approved* the foregoing report and recommendations.

The Policy Committee also submitted for the information of the Council information on activity by various groups to change present laws dealing with poor relief tending to further complicate the problem of medical care to the needy. The committee also referred to possible legislation by the pharmacists to restrict physicians in dispensing drugs and analyzed the attitude of the Ohio State Pharmaceutical Association in attempting to eliminate from the retail commodity sales tax passed by the Legislature, the exemption on incidental dispensing of medicine and similar articles in connection with professional service.

Possible legislation in regard to the State Department of Health, public health nursing, proposals by the cults and other legislative problems were analyzed.

POLICY ON AUTOMOBILE INJURY CASES

On behalf of the Policy Committee, Dr. Upham submitted the following report and recommendations:

A number of times during the past four years the Council of the Ohio State Medical Association, with the approval of the Policy Committee, has declined to endorse or support a proposal to include medical service for reimbursement in legislation which provides compensation to hospitals for services rendered to indigents injured in automobile accidents. (Reference to previous policy, Council minutes, January, 1933, *Journal*, page 46).

The reason set forth by the Council and the Policy Committee for its position at that time was based on the principle that it would be inconsistent to support a proposal for centralized, governmental medicine for one type of disability and to continue to oppose general socialization of medicine. It also was pointed out at that time that the medical profession was divided in its attitude on this question, and that the reason for the provision covering hospital service was not only on account of the financial difficulties of those institutions, but because they were actually at a financial loss in caring for prolonged cases of automobile injuries.

In order to release certain funds in the Highway Department for other uses, which funds had been segregated under the provisions of the law enacted in 1933 to reimburse hospitals for services rendered indigents injured in automobile accidents, Governor White submitted a special message to the Legislature at its session in December, 1934, calling for the re-enactment of the hospital bill and for the extension of its provisions beyond March, 1935, the termination date of the original act of 1933, and as a part of the State Administration program this bill was enacted.

In view of contemplated legislation for a complete reorganization of the relief set-up for the care of the needy, including medical care, and possible reorganization of local governmental functions of this nature taken in connection with proposed changes in the relief situation under the FERA, we consider it inadvisable as well as impractical to ask the Legislature in the coming session by a special bill to compensate physicians for services rendered to those injured in automobile accidents, as these cases are relatively few and entirely incidental to the large problem of medical care to the needy generally.

Our recommendation in this matter is further actuated by the fact that there is a definite constitutional question concerning the legality of the diversion of funds such as those expended from the Highway Maintenance Fund through the sale of automobile license tags and administered by the State Highway Department; and the further fact that even if we were able to secure the enactment of such a special measure it would only be after serious difficulties which might weaken our position with members of the Legislature on other much more important legislation generally affecting medical practice and public health administration, with the added possibility that if such a special bill would become a law, that it might be thrown out by the courts. (In this connection the question of the legality of the diversion of funds for hospital services is pending in the courts at the present time).

Moreover, the hospital reimbursement statute is not confined strictly to indigents and those legally defined as needy, but merely to those who cannot or do not pay their hospital bills within 90 days and thus to approve this principle would open up the field of governmental medicine for others than those actually in need.

Consistent with the established policy, we be-

lieve that provision should be made through local governmental administrations (either with the aid of federal-state funds or otherwise) to reimburse physicians for services rendered to indigents as well as to those temporary in need. This policy is not inconsistent with our general opposition to an elaborate system of governmental medicine or socialization of medicine to include medical care for citizens generally, especially those who are able to pay for their own medical service.

This statement constitutes a reaffirmation and clarification of policy already established.

On *motion* by Dr. Huston, seconded by Dr. Klotz and *carried*, the foregoing was *approved* and *adopted* as the expression of Council.

REFERENCE HANDBOOK

The Policy Committee reported to the Council on the preparation of a legislative reference handbook, being a revision and enlargement of previous handbooks of this nature, for distribtuion to the incoming members of the Legislature, to the legislative committeemen, the presidents and the secretaries of the county medical societies. Dr. Upham emphasized some of the numerous subjects included in the index to this publication, which is expected to be off the press and ready for distribution within a week following this date. Emphasis was placed on the importance of having those who receive the handbook preserve it for reference from time to time as legislation is pending on various subjects discussed and analyzed in the handbook.

COMPLIMENTS TO HEALTH DIRECTOR

Reference was made to the appointment by the incoming Governor of Dr. Walter H. Hartung, Toledo, as the new State Director of Health to take office with the incoming state administration on January 14. His qualifications and experience were discussed and plans suggested for cooperation with him.

Dr. H. G. Southard, the present State Director of Health, being present at the Council meeting, on suggestion by Dr. Upham and on *motion* by Dr. Goodman, seconded by Dr. Hendershott and *carried*, the Council expressed appreciation for the splendid service rendered by Dr. Southard and for his close contact and cooperation with the Policy Committee and the Council on numerous problems of health administration and medical practice.

DENTAL CONTACT COMMITTEE

The President, Dr. Caldwell, reported on a conference held the preceding evening with the Legislative Committee and other officers of the Ohio State Dental Society, and pursuant to a request and agreement at that time, and with the consent of the Council at this time, Dr. Caldwell appointed the following committee representing the Policy Committee and the Medical Economics Committee as a contact committee with a similar committee of the State Dental Society:

Dr. J. H. J. Upham, chairman, Columbus
Dr. J. B. Alcorn, Columbus
Dr. L. L. Bigelow, Columbus
Dr. H. M. Platter, Columbus
Dr. C. W. Stone, Cleveland.

PROBLEMS OF SOCIALIZATION

Dr. Upham and Dr. Stone reported in detail on developments, national and state, toward the socialization of medicine through legislation and governmental administration. Reference was made to the activity of President Roosevelt's Committee on Economic Security and of the interlocking directorate between the staff of that committee and the American Association for Social Security, Inc., which is fostering a uniform bill for governmental sickness insurance to be introduced in the various state legislatures; the American Association for Labor Legislation, and the various official connections of Edwin E. Witte, executive director of the President's Committee on Economic Security.

Analysis was made of the activities and contacts established by representatives of the American Medical Association on nation-wide, and of the State Medical Association on state-wide, problems in this field.

Special reference in this discussion was made and the attention of all members was again called to the detailed analysis published on pages 827 to 833, inclusive, of the December 1 issue of the *Ohio State Medical Journal*.

Attention was called to the organization by the Ohio Chamber of Commerce of a Committee to Study Socialization of Medicine, and the prospects of other business groups taking a direct interest in this field.

Emphasis was placed on the importance of each component academy and county medical society being alert and informed on this question and prepared to submit information and the correct medical policy to the members of Congress and the State Legislature.

WORKMEN'S COMPENSATION DEVELOPMENTS

Dr. Hein reported on developments in workmen's compensation administration. He referred to some of the recommendations of the Special Workmen's Compensation Committee of the Ohio State Medical Association to the Governor's Investigating Committee of the Workmen's Compensation Law, and announced the prospects for incorporation of a number of those recommendations in the forthcoming report of the Governor's committee. He also analyzed changes in administrative procedure at the Industrial Commission with closer contact between the Claims, the Medical and the Legal Departments of the Commission.

Dr. Hein announced that whereas the reserve of the workmen's compensation fund as of Decem-

ber 6, 1933, was $35,792,449.53, it had increased to $38,402,988.58 on December 6, 1934.

He also reported that the increase in the reserve is accounted for by closer inspection, more thorough pay-roll audit and a special enforcement drive put on by the Commission to force employers coming under the law to comply by the payment of premiums. After experience of several years, it was found that many employers were not covered under the Workmen's Compensation Law as they should have been and as they are required by the law to be.

A year ago the average accumulated cases for first-hearing totalled, at any one time, approximately 8,000. By speeding up the handling of cases and the inauguration of more efficient methods, the accumulated cases for first-hearing, at any one time, now average 2,000.

From an average of 30 to 60 days before first-hearing of cases after being filed, the time now has been cut to from 6 to 8 days. While the accumulation of rehearing cases is still heavy, efforts are being made through improved administrative system to speed up these cases.

FURTHER COMMITTEE APPOINTMENTS

Upon the authorization of the Council, President Caldwell appointed the following *special* committees:

SPECIAL WORKMEN'S COMPENSATION COMMITTEE

Dr. B. J. Hein, chairman, Toledo
Dr. L. L. Bigelow, Columbus
Dr. J. Craig Bowman, Upper Sandusky.

(The latter two being members of the Standing Committee on Medical Economics, which committee has functioned for a number of years in connection with workmen's compensation questions).

COUNCIL JUDICIAL COMMITTEE

Dr. C. L. Cummer, chairman, Cleveland
Dr. E. R. Brush, Zanesville
Dr. C. W. Kirkland, Bellaire.

PREVENTIVE MEDICINE AND PERIODIC HEALTH EXAMINATIONS COMMITTEE (Reappointment)

Dr. V. C. Rowland, chairman, Cleveland
Dr. C. W. Burhans, Lakewood
Dr. Jonathan Forman, Columbus
Dr. Beatrice T. Hagen, Zanesville
Dr. R. R. Hendershott, Tiffin
Dr. A. J. Skeel, Cleveland
Dr. C. I. Stephen, Ansonia.

MILITARY AND VETERANS' AFFAIRS COMMITTEE (Reappointment)

Dr. Louis Feid, Jr., chairman, Cincinnati
Dr. John A. Sipher, Norwalk
Dr. A. J. McCracken, Bellefontaine.

AMENDMENTS TO CONSTITUTION AND BY-LAWS

Dr. Smith presented for the consideration of the Council several minor and corrective amendments to the Constitution and By-Laws of the Academy of Medicine of Cincinnati. Dr. Caldwell pointed out that these amendments were not in conflict with the Constitution and By-Laws of the State Medical Association.

On *motion* by Dr. Seiler, seconded by Dr. Hendershott and *carried*, these amendments were *approved* and *authorized*.

Dr. Jenkins submitted for Council consideration minor amendments to the Constitution and By-Laws of the Academy of Medicine of Cleveland.

On *motion* by Dr. Jenkins, seconded by Dr. Seiler and *carried*, the amendments were *approved* and *authorized*.

PUBLICATION PROBLEM

Dr. Rogers, chairman of the Publication Committee, reported to the Council on a paper presented at the last Annual Meeting in the Section on Obstetrics and Pediatrics in which a trade-name appeared, contrary to the action of the Council at its meeting on July 8, 1934, in which the Council issued instructions that "the specific trade-name should be deleted from the title and the paper if it is to be accepted by the Program Committee and presented at the Annual Meeting".

On behalf of the previous Program Committee, Dr. Platter pointed out that neither the title or the abstract as published in the official program set forth the trade-name, although the manuscript as presented at the Annual Meeting and as submitted to the Publication Committee carried such trade-name.

Several motions having been made and defeated and various Councilors having discussed the subject, on *motion* by Dr. Huston, seconded by Dr. Smith and *carried*, the Council authorized and extended approval to the Publication Committee to proceed in accordance with its constitutional authority.

MEMBERSHIP STATISTICS

Statistics submitted for the information of the members, showed 5,352 members paid to date for 1934, compared with 5,165 on the same date last year and with the total for last year of 5,187; 922 members paid in advance for 1935 as compared with 718 paid in advance for 1934 on the same date last year. Dr. Caldwell, the President, emphasized the necessity for Councilors to encourage the payment of 1935 annual dues in advance, and reference was made to arguments on the importance and necessity of membership in the President's Page in the December *Journal*, page 825.

MISCELLANEOUS

Information was submitted and discussed concerning prospective changes in policy, procedure and personnel in the administration of the State Relief Commission, plans and statements announced in the newspapers by Governor-elect

Davey, and prospective changes in the FERA in Washington.

Dr. Davidson announced a request to him, as Councilor, from the Richland County Medical Society to be transferred from the Sixth District, and the suggestion that Columbiana County be added to the Sixth District. President Caldwell requested Dr. Davidson and Dr. Kirkland to inquire, investigate and report at the next Council meeting on the sentiment and reasons for and against such transfers.

Dr. Smith reported briefly on the high-points in the recent Ohio Welfare Conference in Cincinnati, particularly in relation to the health subjects on the program.

Attention was called to a recent Supreme Court decision on the corporate practice of law, and it was announced that this decision as it affects corporate practice of medicine and possibly legal service features of the Medical Defense Plan will be published in the next issue of *The Journal.*

Dr. Brush reported on the recent announcement of the Governor's Commission on Recodification of Laws on Marriage, Divorce and Probate Procedure, on which he and Dr. E. J. Emerick are physician members.

EXECUTIVE SESSION

At this point the Council went into executive session for a consideration of the report and recommendation of the Auditing and Appropriations Committee of the budget for 1935.

On behalf of the committee, Dr. Hein, the chairman, submitted the following report:

REPORT

In the face of unprecedented problems, the Auditing and Appropriations Committee in submitting to the Council for consideration a suggested budget for 1935, is especially pleased to remind the members of the remarkable accomplishments of medical organization in spite of difficulties and to emphasize the relatively greater need for maintenance of a strong and harmonious medical organization adequately financed and with maximum efficiency of organization machinery.

We are likewise pleased to observe the consecutive interest by the members, their cooperation and support, and the increased membership enrollment during the past year over the preceding year. Information we have assembled shows that the membership in the Ohio State Medical Association during the past several years of uncertainty, hardship and depression has been less adversely affected in the reduction of the number of members than practically all other organizations of a voluntary nature with which we are familiar.

This committee is also pleased to report that in spite of adverse conditions we have not only kept our expenditures well within our budgetary allowance provided by the Council at the beginning of the fiscal and calendar year 1934, but that we anticipate a substantial accumulation which may be added to the reserve at the end of this year.

Undoubtedly "operating costs", particularly in regard to *Journal* printing, other printing, supplies and maintenance, will be increased during the coming months not alone through the relative monetary inflation and the decreased value of the dollar, but because of the constantly increased responsibility and activities which must be assumed by medical organization.

This is especially true when we realize the seriousness of the economic, social and governmental questions which must be met during succeeding months. Many of these have been anticipated and analyzed by the Policy Committee and other committees of our State Association as summarized in legislative bulletins, through our *Medical Journal*, and otherwise.

As previously indicated by the monthly financial statements issued to the Council and due to careful fiscal supervision and efficient management in our headquarters office, disbursements for the current year have been kept well within the authorized budget. Every precaution and safeguard has been maintained. All inactive funds are reserved in government bonds. Funds that would be required before the end of the year were placed on short-time deposit from which source the Association benefited by accrued interest until such funds were needed.

In accordance with custom, the Auditing and Appropriations Committee employed a certified accountant to audit the records and financial transactions of the Association for the preceding calendar and fiscal year, which constituted a part of the last annual report of this committee, published in the October, 1934, issue of *The Journal.* A similar complete and official audit will, of course, be made after the end of the present fiscal calendar year.

In connection with the duties of this committee, all bills were carefully examined and no vouchers were issued until after official approval. Special attention was given to the maintenance of accurate records.

Anticipating, as we must, increased responsibilities necessitating extraordinary activities, we may find it necessary to supplement the proposed budget and we may find it necessary to utilize at least a small amount of our reserve for expenditures during the coming year. Naturally we assume that our reserve is intended to be used for extraordinary purposes and emergencies.

AUDITING AND APPROPRIATIONS COMMITTEE
DR. B. J. HEIN, Chairman, Toledo,
DR. H. S. DAVIDSON, Akron,
DR. A. A. JENKINS, Cleveland.

On *motion* by Dr. Hein, seconded by Dr. Seiler and *carried*, the Council adopted the foregoing recommendations.

Dr. Hein, the chairman, then submitted the tabulated proposed budget as follows:

At this time we recommend a proposed budget approximately the same as that for last year:

	1935 Recommended App'n.	1934 App'n.
Ohio State Medical Journal	$7,000	$7,000
Medical Defense	4,000	4,000
Committee on Public Policy	1,000	800
Executive Secretary, Salary	6,600	6,600
Executive Secretary, Expense	800	800
Ass't. Executive Sec'y, Salary	4,000	4,000
Ass't. Executive Sec'y, Expense	200	200
President, Expense	400	400
Treasurer, Salary	300	300
Council, Expense	600	600

Annual Meeting	500	500
Auditing and App'n. Committee	100	100
Misc. Committee Expense	600	600
Stationery and Supplies	600	600
Postage and Telegraph	800	700
General Counsel	2,100	2,100

On *motion* by Dr. Hein, seconded by Dr. Hendershott and *carried*, the Council *approved* the foregoing budget.

SUPPLEMENTARY RECOMMENDATIONS

Dr. Hein, chairman of the committee, reported the following supplementary recommendation:

The Auditing and Appropriations Committee is especially impressed by the phenomenal amount of detail and duties resting on our efficient and expert headquarters staff. We believe with added details which may be necessary in this emergency that temporary additional personnel may be necessary for research work, etc., as may also be necessary the purchase or preparation and publication of additional literature. For this reason we recommend a special contingent appropriation of $1,500 to be subject to the decision and authorization, on behalf of the Council, by the President, the chairman of the Policy Committee and the chairman of the Auditing and Appropriations Committee, acting jointly.

On *motion* by Dr. Hein, seconded by Dr. Davidson, and *carried*, the foregoing special recommendation was *adopted*.

On *motion* by Dr. Hein, seconded by Dr. Davidson and *carried*, the Council ordered a rebate of $1.00 from the annual per capita dues of 1935 to each member.

On *motion* by Dr. Seiler, seconded by Dr. Brush and *carried*, the Council ordered that such rebate be paid by check from the headquarters office and transmitted to each member in the amount of $1.00 following the receipt of the regular $5.00 per capita annual dues for 1935.

The Council adjourned to meet at the call of the President.

Signed: S. J. GOODMAN, M.D.,
Secretary of Council.

— OSMJ —

$300 Prize For Goiter Essay

The American Association for the Study of Goiter again offers the Van Meter Prize Award of $300 and two honorable mentions for the best essays on the subject of goiter provided they meet the standards of the award committee. The essays should be based on original research work on the subject of goiter, preferably its basic cause. The prize essay or its abridgement is to be presented at the annual meeting of the Association to be held in Salt Lake City, Utah, in June, 1935.

Competing manuscripts should be in the hands of the Corresponding Secretary, W. Blair Mosser, M.D., Kane, Pa., not later than April 1st, 1935.

Dr. Walter H. Hartung, Toledo, New State Director of Health

Dr. Walter H. Hartung, Toledo, has been appointed by Governor-elect Martin L. Davey as State Director of Health.

He will succeed Dr. Harry G. Southard, Marysville, who held the post for four years under Governor White.

Dr. Hartung is 46 years of age; married, and has three children. He was educated in the Toledo public schools and was graduated from the former Toledo Medical College in 1912. Dr. Hartung served his internship in St. Vincent's Hospital, Toledo, where he is a member of the staff.

The new director of health has been active in Democratic politics for many years. He served as coroner of Lucas County from 1916 to 1920 and was an unsuccessful candidate for mayor of Toledo several years ago.

He will assume his official duties on January 14, the day the new state administration is inaugurated.

— OSMJ —

Attorney General Renders Opinion on Hospitalization of Tubercular

In answer to requests for legal opinions regarding the hospitalization of indigent tubercular and indigent epileptic, Attorney General John H. Bricker has rendered an opinion, (No. 3529), the syllabus of which is as follows:

1. The county of legal residence of persons afflicted with tuberculosis should hospitalize such residents. "Legal settlement" of such persons within the county is not a necessary requirement. The expense of treatment in the hospital for tuberculosis should be paid by the county of "legal residence" if such persons is indigent.

2. By virtue of Section 1816, General Code, when an indigent epileptic person, neither insane nor dangerous, is committed to an institution for epileptics, the county from which the indigent person is committed is liable for the necessary clothing and incidental expenses of the indigent epileptic person at such institution.

3. By virtue of Section 2045, General Code, the probate court of the county in which the epileptic is resident has jurisdiction to commit such person to the State Institution for Epileptics. A "legal settlement" is not a necessary requirement before an indigent person may be committed by such court to such institution.

— OSMJ —

The United States Public Service has announced revision of two pamphlets on sex education for adolescent children which may be purchased at five cents per copy from the Superintendent of Documents, Government Printing Office, Washington, D. C.

SERIOUS, IMMEDIATE LEGISLATIVE PROBLEMS CONFRONT THE MEDICAL PROFESSION FOLLOWING DECEMBER TAX SESSION

AN emergency taxation program estimated to yield between $70,000,000 and $80,000,000 for the relief of the public schools and political subdivisions of the state and provide part of the money that will be needed during the ensuing year to finance old age pensions and poor relief, was enacted in December by the 90th General Assembly and approved by the Governor, bringing to a close one of the most turbulent sessions ever held by Ohio's law-making body.

The revenue-producing program finally agreed upon by the State Legislature after 23 months of wrangling and virtual deadlock on taxation matters and during which time it was in almost continuous session considering emergency legislation of one kind or another is a temporary combination of several types of taxes.

It is designed to raise revenue quickly and in amounts sufficient to meet the financial emergency confronting the schools and almost bankrupt political subdivisions.

The acts which make up the program, effective only during the calendar year 1935, are:

A bracket-coupon tax on retail sales of tangible personal property, estimated to produce at least $60,000,000.

A 1-cent-a-gallon tax on liquid fuel, estimated to produce $10,000,000; re-enactment of a similar measure passed by the General Assembly a year ago.

A 3 per cent tax on the gross receipts of theaters and other places of amusements, estimated to yield $3,0000,00; suspending for one year the 10 per cent amusement tax which had been in effect during 1934.

An increase of 1 per cent in the excise tax on public utilities, estimated to raise in the neighborhood of $2,000,000.

An increase of the tax on income-producing investments from 5 per cent to 6 per cent, estimated to yield approximately $1,500,000.

VETO THREAT SPEEDS ACTION

The hike in the tax rate on income-producing investments was the last measure of the program considered and enacted by the General Assembly. It was rushed through the Assembly in record-time in compliance with an ultimatum issued by Governor White, stating that he would veto the sales tax bill, the principal revenue-producing proposal, unless the Legislature enacted some measure taxing earned or unearned income.

Before the Governor's veto threat was issued, the Senate had defeated a graduated tax on both earned and unearned incomes which had passed the House.

Rather than see the whole emergency taxation program collapse in the face of desperate situations confronting the schools and political subdivisions, enough members of the Senate waived objections to the enactment of any kind of income tax at this time and supported the measure increasing the rate on income-producing intangibles to assure its passage. It met with little opposition in the House where sentiment for an income tax had been overwhelming throughout the entire session.

One of the principal reasons the proposed graduated income tax bill was not enacted was because it would not have produced any revenue before 1936 since it could not have been levied on 1934 income under provisions of the Constitution relative to retroactive taxation. Some members of the Legislature also pointed out that the program before them was solely an "emergency" set-up and that any tax which could not produce revenue quickly should not be considered.

PROFESSIONAL SERVICES EXEMPTED

The tax levied under the retail sales tax act does not apply to and specifically exempts "professional or personal service transactions which involve sales as inconsequential elements, for which no separate charges are made".

Services rendered by a physician for a professional fee and when no separate charge is made for medicine, materials, appliances, etc., furnished by the physician are, therefore, not taxable under this exemption, secured and retained by the Policy Committee of the Ohio State Medical Association while the measure was under consideration.

It also exempts sales of tangible personal property of 8 cents or less, sales of newspapers, fluid milk sold for consumption off the premises, bread in loaf form, farm products sold by the producer on his own farm or from property he owns, products sold by charitable organizations when the proceeds are used for philanthropic purposes, casual and isolated sales by a person not engaged in the business of selling tangible personal property, and feed, seeds, lime and fertilizer. The retail sales tax does not apply to articles on which there are other state taxes, such as liquid fuel, cigarets, beer, liquor, etc.

About $24,000,000 of the money raised by the sales tax will be distributed to the public schools on the basis of their average daily attendance; approximately $16,000,000 will be allocated to political subdivisions; $6,000,000 will go to the state poor relief fund; $4,000,000 will be used to retire poor relief bonds issued by the counties, and $6,000,000 to the old age pension fund.

Under the bracket plan, a 1 cent tax will be

levied on all taxable sales between 9 and 40 cents; 2 cents on sales between 41 cents and 70 cents and 3 cents on sales between 71 cents and $1.00. If the price of the article sold is in excess of $1.00, three cents will be collected on each full dollar thereof. If the price is not an even number of dollars, in addition to the tax on each full dollar, the bracket rates will apply to each portion of the uneven amount.

Each retailer must obtain a license and collect the tax from the purchaser. As the tax is paid, a coupon equal to the tax is cancelled by the retailer by tearing it into two parts, one of which is retained by the merchant and the other is given to the purchaser. The coupons must be purchased by the retailer from the state or county treasurers or authorized agents and he is reimbursed by collecting the tax from the consumer.

SENTIMENT FOR INCOME TAX STRONG

The tax program enacted by the 90th General Assembly at its "lame-duck" session, held only a few weeks before its tenure of office expired, is expected to adequately take care of the financial needs of the cities, counties and schools during 1935.

However, it leaves to the 91st General Assembly, the members of which were elected at the November general election and which will convene Monday, January 7, the onerous task of formulating and enacting a permanent taxation system as a substitute for the hodge-podge program which will be in effect during 1935.

Before it is many days old, the incoming Legislature will doubtless be in the throes of a battle over taxation which may by comparison overshadow the one which on more than one occasion threatened to wreck the expiring Legislature.

The present indications are that the 91st General Assembly will endeavor to start at scratch in the consideration of financing and taxation problems. There is no way of knowing at present what type, or types, of taxation will be devised to take effect upon the expiration of the emergency acts passed by the outgoing General Assembly.

Views of the 73 members of the last Legislature who will occupy seats in the 91st General Assembly are known to differ greatly on matters of taxation. Some who supported the temporary retail sales tax did so because of the emergency confronting the schools and political subdivisions but are opposed to making this type of taxation permanent. Others believe it should remain as the base for a permanent system. A considerable number favor a graduated income tax as part of a permanent system.

Undoubtedly tremendous pressure will be exerted on the members of the 91st General Assembly by the proponents of an income tax and similar measures predicated on the theory that taxes should be levied on the basis of ability to pay.

Several movements are under way at present to have circulated throughout the state initiative petitions which would place on the ballot next November proposals eliminating all taxes on real estate and personal property and providing for the levy of a high tax on gross earned incomes, and other forms of radical taxes.

It has been pointed out by some observers that the circulation of these petitions may have the effect of speeding up enactment by the next Legislature of a permanent tax program in order to prevent, if possible, hasty action by the people in voting for ill-advised and radical tax proposals submitted to them through initiated petitions without having an opportunity to study or understand their provisions. However, others are not optimistic that the taxation question will be solved before months of bitter wrangling and much maneuvering.

HOSPITAL FEE MEASURE RE-ENACTED

Some miscellaneous legislation was passed, consisting chiefly of corrective amendments to acts now in effect and measures extending the time of several emergency relief laws.

As a part of the State Administration legislative program submitted to the General Assembly in special messages by Governor White at the December session, the Legislature re-enacted the law enacted in 1933 providing for reimbursement of hospitals from the state highway maintenance and repair fund for services rendered indigents injured in motor vehicle accidents and extending the provisions of the act beyond March, 1935, the termination date of the act of 1933.

It was pointed out by the Governor in his special message that enactment of the measure was necessary to release certain funds to the State Highway Department which had been segregated under the provisions of the hospital act and which were not needed for reimbursement of hospitals but under the provisions of the act could not be used for highway maintenance and repair.

A number of appointments made by Governor White to various state boards, commissions, etc., were acted upon favorably by the Senate, including the appointment of Dr. J. H. J. Upham, Columbus, as a member of the State Medical Board for the term ending March 18, 1941, and Dr. Lewis T. Franklin, Chillicothe, as a member of the board for the term ending March 18, 1940.

MAJORITY OF NEW MEMBERS FIRST TERMERS

Well-informed legislative prognosticators have predicted that the session of the 91st General Assembly will be in many respects similar to that of the 90th and will be marked with heated factional and partisan clashes and sharp differences of opinion concerning ways of meeting acute economic and governmental problems.

One factor that doubtless will make the next session of the State Legislature even more com-

plicated, uncertain and hectic than those of the past is that a majority of the members of the 91st General Assembly will be first-termers and without legislative experience.

The official roster of the membership of the 91st General Assembly shows that of the 19 Democrats and 13 Republicans elected to the Senate, 10 have never served in the Legislature.

In the House, 84 of the 68 Republican and 67 Democratic members are first-termers.

As 94, or considerably more than half, of the 167 members of both houses will be inexperienced in legislature procedure and have no legislative record, their attitude toward various issues of public interest, including public health and medical questions, will in many instances be unknown.

Incidentally, the new and inexperienced members of the Legislature, especially, will be beseiged by individuals and groups backing questionable, radical and destructive legislation. There is always the danger that new members will let themselves be tricked into supporting deceptive proposals, many of which have failed repeatedly in previous legislative sessions. Unless a majority of the Legislature are able to resist outside pressure and remain open-minded on all questions until they have an opportunity to analyze carefully the provisions of each bill and to seek competent advice, foolish and detrimental legislation may be enacted.

MANY MEDICAL PROPOSALS ANTICIPATED

It may be definitely predicted that an unprecedented number of bills in which the medical profession will be vitally interested will be introduced in the 91st General Assembly.

For this reason, the medical profession, through medical organization, must be even more alert and aggressive during the ensuing months in its legislative activities than in the past.

In addition to matters of taxation, in which all physicians as citizens and taxpayers are interested, some of the questions having health and medical angles which may be considered by the Legislature include:

Changes in the public health laws and in public health administration, through alternative plans for the reorganization of county government, or otherwise; extensive modification in the present laws dealing with poor relief, including medical care of the needy; social insurance, including compulsory state health insurance; amendments to the Workmen's Compensation Law; attempts to change the Medical Practice Act; welfare legislation of various kinds; legislation pertaining to hospitals, nurses, druggists, dentists, etc.; automobile legislation, including a drivers' license law and drivers' financial responsibility law; anti-vaccination and anti-vivisection proposals; changes in the criminal, probate, election, jury and school laws; attempts of cults to obtain greater privileges in their limited practice; Christian Science and faith healing proposals.

Much of this anticipated legislation will be of direct interest to physicians. They should be especially concerned as to the action of the Legislature on measures which especially relate to public health, scientific medicine, medical practice and medical care.

The present policies of the medical profession on these questions are clear and definite. In contacting members of the Legislature, physicians should explain the concerted medical viewpoint on health and medical matters and point out to them why they should seek information and advice on these questions from their physician constituents.

HEALTH SAFEGUARDS MUST BE MAINTAINED

Statutory provisions in Ohio for official public health activities have proved themselves of immeasurable benefit to the public at large. Ohio's program of prevention and promotion of public health is recognized as one of the best in the country. Changes in existing laws or regulations which would weaken public health safeguards or cripple administration of the public health laws should not be enacted. All proposals advocating modification of the health laws should be considered on the basis of public benefit and administrative efficiency. For obvious reasons public health administration should be retained as an independent, responsible function of local government. It should receive adequate support from public funds so that it can carry on effectively the innumerable important activities in this field of public service.

Anticipated proposals providing for optional forms of county government undoubtedly would involve some modification of present forms of local public administration as pointed out in the November, 1934, issue of *The Journal*, pages 769-772, together with changes in local systems of providing relief, including medical care, for the needy. For that reason, physicians should be activtly interested in plans under way or contemplated calling for governmental reorganization.

For obvious reasons, the medical profession should be intensely interested in any proposal which contemplates modification of the Medical Practice Act, which in its present form is a safeguard to public health and a vital factor in maintaining the practice of medicine in Ohio on a high plane.

ATTACKS ON MEDICAL LAWS EXPECTED

No changes in the Medical Practice Act are necessary at this time. The present medical practice statutes are reasonable, fair and just. Court after court has held them so. They grant to all desiring to practice the healing arts privileges commensurate with their educational qualifications and competence, upon satisfactory proof. They insure high standards of medical practice

and protect the sick against unqualified practitioners by requiring all to meet definite educational and training requirements and restricting the practice of those with inferior training.

Some groups of cult and limited practitioners will again besiege the Legeslature for special privileges, seeking enactment of proposals that would permit them to practice medicine in an unlimited way without meeting the same high requirements demanded of regular physicians. Such measures should be defeated, the fate they have met repeatedly in previous sessions of the Legislature.

Attacks on scientific medicine probably will be made by cultists, fanatics and those with anti-medical complexes. An effort may be made by them to obtain support among legislators for measures which would have a detrimental effect on the vaccination and quarantine laws and regulations, animal experimentation in medical research, and destroy medical standards. Naturally, such measures should be defeated.

WORKMEN'S COMPENSATION PROPOSALS

Proposals to amend the Workmen's Compensation Act will be introduced. Some of these will be sponsored by groups and organizations which have devoted much thought to ways to strengthen the law and improve its administration and are seriously and sincerely interested in the workmen's compensation system. Obviously all measures affecting the workmen's compensation system should be considered from the standpoint of whether or not they are for the best interests of beneficiaries of the state insurance fund and others directly interested in the system. Crippling and reactionary proposals should be defeated. Proposed legislation in the field of workmen's compensation should be of vital interest to members of the medical profession, whose attitude toward revision of the compensation law should be based on definite policies of medical organization incorporating the principles just enumerated.

SOCIALIZED MEDICINE AN ISSUE

There are strong indications that the 91st General Assembly will be called upon to consider one or more measures providing for some type of sickness insurance as part of a general program of social insurance, controlled and partially financed by government.

Certain social welfare groups in Ohio are contemplating making a determined campaign for enactment of an all-inclusive social insurance program.

In addition, several national organizations, notably one known as the American Association for Social Security, Inc., are planning to have a proposal providing for compulsory health insurance introduced in every state legislature during the ensuing year, including Ohio.

The advocates of social insurance legislation are capitalizing on present financial conditions, public unrest and the sympathy of the national administration for social insurance. They are said to be optimistic over their chances in Ohio and elsewhere.

On various occasions *The Journal* has commented in detail on the extensive drive being staged for radical changes in the present system of distributing medical service and for the establishment of a compulsory, government-administered health insurance system on a national or state-wide basis. The latest developments on this question were summarized in the December, 1934, issue of *The Journal*, pages 827-833.

Organized medicine must be prepared to meet this impending crisis and should start at once, if it has not already been done, to acquaint members of the 91st General Assembly with the concerted medical viewpoint on the socialization of medicine as summarized in the last annual report of the Committee on Public Policy of the State Association, published in the October, 1934, issue of *The Journal*, pages 658-664.

LOCAL ACTIVITY ESSENTIAL

This brief summary of trends and developments incidental to the coming session of the General Assembly and enumerating a few of the vital issues involving health and medical questions indicates in a general way why organized medicine in Ohio must be alert and unusually active during the coming legislative session.

As usual, legislative developments at Columbus will be followed closely by the Committee on Public Policy and headquarters office staff of the State Association. Proposals of interest will be analyzed and information regarding the progress of legislation will be sent in bulletins issued by the committee to local legislative committeemen who are responsible for passing on information to their colleagues and directing local activity.

Members of the Legislature will, or should, listen to their physician constituents on health and medical questions. For that reason, local initiative and activity are vital. Every physician should feel it a personal duty to interest himself in legislative matters and assist his colleagues in providing local legislators with accurate information and sound advice on matters pertaining to public health, scientific medicine and medical care.

The Committee on Public Policy has re-issued a revised edition of the Legislative Reference Handbook setting forth in detail the attitude and policies of organized medicine in Ohio toward numerous public questions, and legislation and governmental administration affecting public health, scientific medicine, medical practice and medical care.

This handbook has been sent to members of the Legislature and other public officials, and to local legislative committeemen and county society

officers. It should be referred to frequently by the legislative committeemen in furnishing legislators with correct information and the medical viewpoint on public questions and in analyzing the policy of organized medicine on such questions at county society meetings when opportunity is offered for discussions of legislative and governmental matters.

Study Outline No. 7

SKIN CANCER (CARCINOMA)

By H. J. PARKHURST, M.D.,
TOLEDO, OHIO

OUTLINE FOR STUDY

1. BASAL CELL EPITHELIOMA
(The commonest skin cancer, only locally malignant).

A. Clinical Varieties:
(1) Flat rodent ulcers (the commonest type, sometimes cystic)
(2) Nodular cancers
(3) Rolled-edge rodent ulcers
(4) Depressed scar-like cancer
(5) Morphea-like cancer
(6) Fungating tumors
(7) Deep ulcers

B. Location: Usually on face; sometimes on upper trunk; rare on extremities.

C. Origin: Practically always from keratoses (senile or seborrheic) largely due to action of actinic rays of sun. Light skins susceptible. Extremely rare in negroes.

D. Course: Usually very slow; no metastases.

E. Pathology: Derived solely from basal cell layer of epidermis. Mixed types (basal and prickle cell epithelioma) are found to occur in perhaps 10 per cent clinically diagnosed as basal cell epithelioma. Therefore biopsy study is always advisable.

F. Prognosis: Pure basal cell epitheliomas are fatal only through secondary infection or through invasion of vital structures.

G. Treatment: Total removal or destruction is essential, including a margin of normal surrounding. Cosmetic result always of secondary importance.

(1) Methods:

(a) *X*-rays (at least 1½ erythema dose, repeated every 4 weeks, and one more treatment after apparent cure. Treat a margin of ¼ inch all around the tumor, to insure destruction of outlying cells). Technic varies with depth of tumor.

(b) Radium (similar to *X*-rays) type of applicator and technic varies with depth of tumor.

(c) Electrocoagulation (bipolar current).

(d) Excision (with good margin). (Especially useful when cartilage of eyelid, nose or ear is involved, such cases being resistant to irradiation).

(e) Arsenical paste, etc., not recommended.

(2) Results: Recurrences rare if operator is experienced.

2. PRICKLE CELL OR SQUAMOUS CELL EPITHELIOMA
(Usually primary; rarely secondary to cancer of other organs).
Differs usually from basal cell epithelioma clinically:
Deeper and tending to fungate.
Involves regional lymph nodes and metastasizes.
Cancers of lip, oral mucosa and genitalia are of this type.
Fairly common on hands and fingers, and cancers of covered parts are likely to be of prickle cell type.
Much less frequent on face than basal cell cancer. (Often discovered by routine biopsy examination).

A. Origin: Individual susceptibility, which may be hereditary, plus the following factors:
Keratoses (senile or seborrheic). Occupational contact with tar or paraffin is sometimes a predisposing element.
X-ray Karatoses
Arsenical Keratoses
Leukoplakia
Scars (Especially following third degree burns)
Scars from lupus vulgaris, etc.

B. Course: Usually rapid, with metastases
C. Pathology: Derived from prickle or squamous cells of epidermis. Biopsy study always advisable to determine grade of malignancy (Broders), an aid in prognosis and treatment.
D. Prognosis: Fatal unless treated early and thoroughly.
E. Treatment: Total removal or destruction, including margin of normal tissue. Destruction of cancer cells in regional lymph nodes, which may be present even though these nodes are not palpable.
(1) Methods: Depending upon location, depth and grade of malignancy, etc.
(a) Surgery, especially electrosurgery.
(b) Radium (better imbedded in tumor; enjoys this advantage over *X*-rays).
(c) *X*-rays (including thorough exposures of regional lymph nodes).
(d) (Combinations of the above methods are generally required, irradiation preceding and following surgery).
(e) Amputation (required in certain cases).
(2) Results: Unfavorable if metastases have occurred.
In any case, recurrences are all too frequent.

3. PAGET'S DISEASE

A prickle cell epithelioma of the breast (sometimes occurring elsewhere), originating either in an eczematoid patch or in the mammary ducts. Irradiation, surgery, or both are required.

Suspect Paget's disease if unilateral chronic eczema of breast does not yield promptly to protective applications.

4. MELANOEPITHELIOMA

A. Origin: From blue-black, smooth, hairless moles, especially those which have been irritated or incompletely removed.
B. Course: Usually very rapid, metastasizing through blood stream and lymphatics.
C. Pathology: Resembles structure of pigmented mole from which tumor developed. Tumor cells often extend widely into surrounding tissues.
D. Prognosis: Fatal, but there is some hope if thoroughly treated before metastases have occurred.
E. Treatment: Very wide and deep excision by cautery knife, or electrocoagulation, preceded and followed by intensive irradiation with *X*-rays or radium, with wide margin. Serial sections of excised tissues are essential, to insure complete removal. Regional lymph nodes should be removed or irradiated. Amputation of limb may be required. Results: Sometimes good, but usually unfavorable.

5. DIFFERENTIAL DIAGNOSIS OF SKIN CANCER

A. Syphilis (chancre (especially extragenital) and gumma)
D. Lupus vulgaris; tuberculosis verrucosa Cutis
C. Traumatic ulcers
D. Dermatitis vegetans
E. Vegetating bromide or iodide eruption
F. Granuloma pyogenieum
G. Sporotrichosis
H. Blastomycosis
I. Lupus erythematosus
J. Morphea

6. PREVENTION OF SKIN CANCER

A. Avoid over-exposure to ultraviolet rays (natural or artificial) or to *X*-ray or radium.
B. Avoid prolonged or repeated administration of pentavalent arsenical compounds (prescriptions or proprietary remedies).
C. Remove keratoses by electrodesiccation, through curettage, excision or irradiation (*X*-rays or radium).
D. Prevent local irritation of any kind, especially irritation of the mucosa by jagged teeth or ill fitting dentures, or by tobacco.
E. Remove leukoplakia by electrodesiccation. Chemical caustics may do more harm than good.
F. Avoid exposure to tar or paraffin.
G. Do not irritate black moles. If at site of repeated irritation (as on foot) excise completely with wide margin and no regard for cosmetic effect.

SUGGESTIONS FOR PAPERS

1. The Prevention of Skin Cancer.
2. The Diagnosis of Skin Cancer.
3. The Treatment of Skin Cancer.

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6. Radium Therapy in Carcinoma of the Lip. *Kelly, Edmund*, J.A.M.A. 100:388 (Feb. 11), 1933.

7. The Origin of Cancer. (Editorial) J. A. M. A. 102:214 (Jan. 20), 1934.

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9. Malignant Melanoses Arising in Moles: Report of Fifty Cases. *Butterworth, Thomas*, and *Joseph V. Klauder*, J.A.M.A. 102:739 (March 10), 1934.

10. The Present Status of Radiation in the Treatment of Cancer: Clinical Lecture at Cleveland Session. *Christie, Arthur C.*, J.A.M.A. 103: 985 (Sept. 29), 1934.

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— OSMJ —

1933 Adds Another Year of Decline in State's Mortality Rate

Final compilation of mortality statistics in Ohio for 1933 completes a constant decline in death rate during the last five years, which constitutes one of the biggest assets the State possesses, declares *The Ohio Health News*, which adds: This reduction is evidence of the service of the medical profession and the constant watchfulness exercised by health authorities in carrying out a well-ordered program of health.

The number of deaths for 1933 was 73,052, with a rate of 10.5 per 1,000 population, the lowest death rate recorded since the beginning of registration, and compared with 76,216 for 1932, rate 11.1. Much has been written concerning the increased toll from diseases of the heart, cerebral hemorrhage, diabetes and automobile accidents, but even these causes witnessed reduction in death rates in 1933 from former years, along with decreasing mortality among infants, a remarkable reduction in tuberculosis deaths and the almost complete eradication of smallpox.

The last five years have witnessed some encouraging reports in the saving of lives among children. Fewer deaths from diarrhea and enteritis, under two years, and from diseases of early infancy, have lessened the infant mortality rate. Childhood has been unusually free from illness characteristic of it, namely, diphtheria, measles, scarlet fever and whooping cough. Motherhood has profited by the slight decrease in the puerperal deaths. Both child and adult life have been spared the ravages from tuberculosis and typhoid fever of former years.

Other diseases that recorded declines in 1933 were: Influenza, pneumonia, nephritis, diseases of the respiratory, circulatory and digestive systems.

Only two diseases, acute anterior poliomyelitis and ethargic encephalitis, and five accidental causes, conflagration, accidental falls, street car, railroad and other accidents, rose in the death rates for 1933.

Tabulated below are the principal causes of death, with rates per 100,000 population for the years 1932 and 1933:

	No. 1932	*No.* 1933	*Rate* 1932	*Rate* 1933
Typhoid fever	127	123	2.00	1.77
Smallpox	1	.....	.01	.....
Measles	163	118	2.38	1.70
Scarlet fever	221	218	3.22	3.14
Whooping cough	341	152	4.99	2.19
Diphtheria	222	174	3.25	2.50
Influenza	2,368	1,552	34.62	22.36
Acute anterior poliomyelitis	29	52	.42	.74
Lethargic encephalitis	57	69	.83	.39
Epidemic cerebrospinal meningitis	58	32	.85	.46
Rabies	2	2	.03	.02
Tuberculosis	3,757	3,640	54.93	52.45
Cancer (all forms)	8,003	7,979	117.00	114.97
Diabetes	1,654	1,575	24.38	22.69
Diseases of nervous system	9,093	8,643	132.15	124.54
Cerebral hemorrhage	7,105	6,658	103.88	95.94
Diseases of circulatory system	18,496	18,252	270.41	263.01
Diseases of the heart	16,349	16,221	238.92	233.74
Diseases of the respiratory system	5,887	4,742	86.07	68.33
Pneumonia (all forms)	5,267	4,109	76.00	59.21
Diseases of the digestive system	4,544	4,592	66.43	66.17
Diarrhea and enteritis (under 2 yrs.)	631	548	9.22	7.89
Diseases of genitourinary system	6,248	6,203	91.34	89.38
Nephritis	5,374	5,233	78.57	76.40
The puerperal state	593	579	8.66	8.34
Malformations and diseases peculiar to early infancy	3,423	3,275	51.05	47.18
Suicide	1,310	1,242	19.15	17.89
Homicide	542	533	7.92	7.68
Conflagration	83	102	1.21	1.46
Accidental burns, *conflagration ex.*	344	318	5.03	4.58
Accidental falls	1,490	1,543	21.78	22.23
Railroad accidents	387	417	5.66	6.00
Streetcar accidents	66	83	.97	1.19
Automobile accidents	1,822	1,834	26.64	26.42
All other accidents	1,510	1,619	22.07	24.42
All other causes	3,365	3,389	49.19	48.83
Grand Totals	76,216	73,052	1114.27	1052.56

— OSMJ —

A person is not permitted by law to administer for a fee or compensation of any kind, any drugs or medicines to chicks, unless he is a graduate of a veterinary college recognized by the State Board of Veterinary Examiners and has received a certificate from such board entitling him to engage in the practice of veterinary medicine and surgery, according to a recent opinion of Attorney General John W. Bricker.

WAYS TO IMPROVE AND PROMOTE PUBLIC HEALTH DISCUSSED BY OHIO HEALTH COMMISSIONERS

MANY of the important public health questions the various health departments of Ohio have been called upon to meet during the past year and those which should receive serious attention during the ensuing twelve months were discussed at the Fifteenth Annual Conference of Ohio Health Commissioners with the State Department of Health, held Wednesday, Thursday and Friday, November 14, 15 and 16 at the Deshler-Wallick Hotel, Columbus.

The 1934 conference of the official public health workers of the state was one of the best-attended ever sponsored by the State Department of Health and the program one of the most interesting.

The spirit manifested at the conference indicated that in general the responsibility of protecting and promoting public health in Ohio is in capable hands and that a good job has been done in spite of curtailed revenue and personnel through efficient organization procedure and the loyalty of those engaged in this important function of government.

* * *

One important phase of public health administration which frequently receives little consideration by the public but is nevertheless a vital part of activities designed to safeguard the health and welfare of the people—sanitation and protection of water supplies—was discussed by Dr. H. G. Southard, State Director of Health, in his annual address at the opening session of the conference. The highspots of Dr. Southard's address were summarized in an article published in the December issue of *The Journal*, pages 839-840.

Dr. Southard's analysis of this particular responsibility of public health officials was a historical review of the activities which have been carried on in Ohio over a period of years in the fields of sanitation and protection of public water supplies. It emphasized the importance of official programs of this sort in all communities and was in effect a warning that other types of public health activities will avail little unless this fundamental function is performed effectively.

Dr. Southard impressed upon the assembly that public health administration must solve the vital problems of community health protection before it undertakes on an elaborate scale activities in the field of personal preventive medicine.

* * *

The subject of infections caused by entamoeba histolytica was given much consideration, from a medical and a public health standpoint.

Joel I. Connolly, chief of the Bureau of Public Health Engineering, Chicago Department of Health, addressed the conference on "The Amoebic Dysentery Outbreak in Chicago". Major Connolly presented an outline of the situation which confronted the Chicago health department in the summer of 1933 when the epidemic became alarming and the steps taken by the department to control the outbreak. He explained in detail the comprehensive investigation made by experts during and following the outbreak, emphasizing the fact that the evidence assembled pointed to water contamination as the principal source of the infection, rather than the food-handler theory. Major Connolly stressed the importance of effective and frequent inspections by sanitary engineers of plumbing in public buildings in preventing future epidemics.

The medical aspects of this disease were discussed in a paper on "Amoebiasis", prepared by Dr. Clayton C. Perry, Cleveland, read by Dr. H. A. Crawford, Cleveland, an associate of Dr. Perry, and in an address on laboratory procedure by Dr. Francis Bayless, Cleveland.

* * *

Considerable time was devoted to discussions of the public health angles of tuberculosis, encephalitis, malaria and typhoid fever.

Dr. H. J. Gerstenberger, Cleveland, presented an interesting paper on "Tuberculosis in Children and the Mantoux Test". Dr. Gerstenberger emphasized the importance of subjecting school children to this test, especially those from families having a history of tuberculosis or an active case of tuberculosis. He explained the technique in giving the test and presented statistics showing its efficacy.

A paper on "Epidemic Encephalitis", dealing with his experiences in treating cases and follow-up studies, was read by Dr. P. George Tait, Toledo. Dr. Tait outlined the various treatments used and summarized the different end-results obtained.

Dr. R. D. Worden, health commissioner of Portage County, discussed methods used to combat a malaria epidemic in Portage County, and L. M. Allwardt, bacteriologist for the Ross County and Chillicothe health departments, presented a report on an epidemic due to a typical typhoid bacillus.

* * *

One of the high spots of the three-days program was the address made by Dr. H. L. Rockwood, Cleveland, director of Mt. Sinai Hospital and former health director of the City of Cleveland,

on "Public Health Principles Applied to Domiciliary Institutions".

The domiciliary institutions of Ohio present needs for more consideration in public health programs, Dr. Rockwood stated. Statistics which he presented showed a large proportion of the population of Ohio resides in domiciliary institutions such as hotels, lodging houses, college dormitories, and different types of public institutions.

Dr. Rockwood pointed out that Section 1261-31 of the Hughes-Griswold Act authorizes the district health commissioner to make or cause to be made frequent inspection of all county infirmaries, children's homes, work houses, jails, or other charitable, benevolent or penal institutions, and to make or cause to be made such laboratory examinations of such inmates as may be requested by any state or county official having jurisdiction over such institution.

"This section of the statutes is not compulsory", he said. "It simply authorizes, and it refers particularly to charitable, benevolent and penal institutions. Nevertheless, such a section of the law must be taken to imply that it is a part of the health officer's field of action to concern himself with the health aspects of domiciliary institutions.

"The fact that institutions are operated under other governmental control, or are private enterprises, or that their function is other than charitable, benevolent, or for the housing of delinquents, does not subtract from the position these institutions may occupy on the liability side of the public health ledger. The hotel promoted cases of amebiasis recently in another state; the typhoid cases in a state institution in our own state; still another small outbreak of typhoid in a general hospital under private control, are only a few instances among many where the protective public health principles employed in domiciliary institutions were inadequate, and the end results of these instances increased the incidence of communicable diseases, a subject which every health officer considers his first concern. Efficient method of control of outbreaks of this character is, of course, a creditable performance, but the health officer is placed in a more favorable position at such times if his program can be shown to include an aggressive purpose to prevent instances of this character.

"Before much can be accomplished by placing domiciliary institutions in the public health program of the health officer there should be some attempt to outline and standardize the public health principles involved. There are several obstacles and hurdles that must be overcome in applying these principles of public health after the health officer has recognized their usefulness as a part of his program, including the rather important difficulty raised by lack of finances, but it is my belief that a very important step can be taken by the health commissioners of Ohio if they will take this subject up actively and assume the leadership which I am convinced is needed to give the inmates of our domiciliary institutions the benefit of a definite, practical, and aggressive plan or plans suited to each type of institutions, dealing with their public health needs".

Dr. Rockwood commented on the public health work being done under definite regulations in supervising maternity hospitals. He expressed the belief that similar activities could be undertaken in applying public health principles under definite programs to tuberculosis and general hospitals, hotels, etc.

"The fact that hotel sanitation in Ohio is legally a matter coming under the jurisdiction of another state department does not free the health commissioner of all concern, for reasons already indicated," he said.

"Regardless of the methods by which the health commissioner accomplishes his aims there can be no serious objection to, and there is adequate reason for, his making the sanitation of hotels an object of his concern at least for program making purposes.

"I am not unaware, of course, that in many health districts much has already been accomplished, in not only hotel sanitation by health commissioners, but also in the application of public health principles to other institutions of a domiciliary character. The development of this work however, could, I believe, be made more comprehensive when there is a general state-wide acceptance of the need that domiciliary institutions be placed universally in the public health programs set up for the various health districts.

"I urge that the health commissioners collectively concern themselves with outlining a standard public health policy applicable to the several types of domiciliary institutions, and that individually, the health commissioner include in the public health program for his district, a definite recognition of the needs these institutions present and the opportunities they afford for demonstrating to his entire district the value of the promotional and protective aspects of public health."

* * *

Child hygiene should be one of the major functions of any well-organized health department, Dr. A. L. Van Horn, chief of the Bureau of Child Hygiene, State Department of Health said in an address at the Public Health Luncheon held on the second day of the conference.

Dr. Van Horn pointed out that child hygiene is not an isolated branch of public health administration. He said there are four activities which should be undertaken under this division of public health administration, namely: Maternal hygiene, infant hygiene, the pre-school child and the school child.

"Maternal hygiene has received considerable

attention in recent years for two principal reasons," he said.

"First, we have become cognizant of the fact that the problems confronting us which are concerned with the pre-natal period of infancy are intimately connected with the pre-natal period and that it is only through better pre-natal care that we will ever be able to attain much success in lowering the mortality rate of the newborn.

"Secondly, maternal mortality studies have revealed that too many women die from causes connected with pregnancy and childbirth. Maternal deaths in Ohio have averaged about 700 yearly for the past ten years. To attempt to analyze these statistics as they stand is, of course, useless. There are so many factors which influence the death rate—such as race, age of mother, hospitalization, etc. * * * With the improvement in accuracy of vital statistics it should be possible to come to more definite conclusions from now on."

Dr. Van Horn quoted from authentic studies which indicated that 21 per cent of maternal deaths have followed abortions; the maternal death rate of the colored race is approximately twice that of the white race; 54 per cent of 5,636 women reported on had had no pre-natal examination by a physician, and only one per cent of those who did, had what is recognized as standard pre-natal care.

Dr. Van Horn said that only 14 cities in Ohio attempt to carry on active work in pre-natal care, such cities representing 40 per cent of the total population of the state, and in only five counties is there any attempt to reach rural areas and carry on an active pre-natal program.

"Who are going to be the leaders in this work?" he asked. "Certainly there is a place for a well-planned educational program. It is encouraging to see the recent formation of the Hospital Obstetric Society of Ohio. They are already investigating the maternal deaths which have occurred in hospitals throughout Ohio, and are attempting to perfect the care of the maternal patient."

By exhibiting a series of charts, Dr. Van Horn showed that during the past 10 years there had been a general decrease in the infant death rate in Ohio. Although this is encouraging, he said, there still remain some parts of the state where the infant mortality rate is too high in comparison to the state as a whole. He also pointed out that there has been little diminution in the number of deaths of infants less than one month of age.

"This problem," he said, "is intimately connected with pre-natal care and is the group upon which more attention must be placed. In studying the causes of death during this period it was found that about 50 per cent of them was due to prematurity."

Data presented showed that the infant mortality rate in Ohio had dropped from 122 in 1913 to 53 in 1933. The ten chief causes of infant deaths are: Diarrhea and enteritis, prematurity, congenital debility, congenital malformation, birth injuries, pertussis, accidental causes, tuberculosis and syphilis, and pneumonia.

There has been a tremendous drop in the number of deaths from diarrhea and enteritis, Dr. Van Horn pointed out, adding:

"Prematurity, which in 1913 accounted for about 25 per cent of the deaths represented, accounts for approximately 40 per cent of the deaths shown in 1933, and, as previously stated, these largely occur during the first month of life.

"The deaths from pneumonia have diminished, and although we realize that this as a cause may fluctuate from year to year, I believe we can definitely say that better infant care has accounted for the fewer deaths from respiratory infections. The same might be said of congenital debility.

"As might have been expected, congenital malformations have shown no appreciable change. Unfortunately, the number of deaths from birth injuries remains the same. One would expect the fewer number of deaths from whooping cough could be accounted for by a fewer number of cases in 1933, however, in checking over the number of cases reported during these years I found that there had been only a 25 per cent decrease in the number of cases while there were 75 per cent fewer deaths among infants from this cause. Such an improvement must be at least partially due to a better understanding among the laity of the dangers of pertussis to young infants and to improved standards in infant care."

The drop in the infant death rate from tuberculosis also is evidence of progress in the infant group, Dr. Van Horn said. He urged that more cities and counties undertake active infant health programs, pointing out that only 25 cities and 18 counties are at present carrying on such programs.

The importance of active health work among pre-school children was emphasized by Dr. Van Horn, especially educational programs showing parents the value of complete and frequent physical examinations of children by family physicians so that nutrition problems can be met, physical defects discovered and corrected, if possible, dental care recommended, and the child vaccinated and immunized before entering school. He called attention to the fact that the pre-school age is the best time to meet the habit forming problems of the child and assist him to acquire proper habits and attitudes.

Dr. Van Horn reviewed activities which may be carried on with school children, such as protection against communicable diseases, physical examinations, instruction in physiology and the value of health, school sanitation, etc. He emphasized par-

ticularly the importance of guarding the school child from tuberculosis.

In conclusion, Dr. Van Horn said the responsibility for carrying on educational programs in child hygiene rests with public health officials and that some do not have a definite program to offer in this important phase of public health administration and preventive medicine. He recommended activities such as he had suggested could be undertaken even with curtailed funds and personnel.

* * *

The necessity for accurate registration of vital facts was emphasized in an address by I. C. Plummer, chief of the Division of Vital Statistics, State Department of Health.

In his opening remarks, Mr. Plummer pointed out that many phases of the work of collecting data on births, deaths, etc., is as old as the human race, citing historical references to prove his statement.

"The fact that this registration has continued down through the history of the development of our civilization is proof of its necessity," he said. "If the conditions and life of the people were such in the time of Moses as to demand the registration of the first-born, then why should there be any question as to proper registration today?

"None of us care to accept an inferior quality of goods, which is but a temporary exchange, so why should we foist upon our citizens or attempt to make an inaccurate record of life, (which is permanent), when neither money nor the brain of man can correct or reproduce very many of these records in later years?

"You still find a few good citizens who will say: 'When I was born we did not need a birth record', and they have not come in contact with the need of one today. When I was born more than 50 years ago, we did not need gasoline stations on all the important street intersections. Try closing them up tonight in Columbus and see what a confused public we will have.

"Since the establishment of birth registration in Ohio, with a central office at Columbus, on December 20, 1908, many laws have been enacted and placed upon our statute books making it mandatory for a child to have a birth record at almost every important turn in life.

"Our state owes to every newborn a birth record. When a physician accepts an obstetrical case, there are certain things which are implied. The patient expects these, and the one we are discussing today is a birth record. The patient depends upon the physician to make the record. What would we think of an attorney we employed in an important case if he would fail to make an entry in the case that might invalidate our entire cause? He would soon cease to be our attorney.

"The physician who fails to report a birth within 10 days after the birth occurs violates the state law and subjects himself to a heavy fine. He does an injury to the helpless babe. He robs him or her of his badge of citizenship and violates the confidence of a family.

"I know that you are asking yourself this question: 'Why is Plummer placing so much stress upon the registration of births to a group of health workers who do very little obstetrical work?' I will answer the question for you by saying, the district health commissioners in Ohio are the arteries through which the life blood of the State Department of Health flows to physicians, undertakers, local registrars and health workers in our state.

"If you are slow to take up this part of your work and neglect to explain the value of accurate registration to the citizens in your district, the result is incomplete registration. You have direct contact with your county medical societies, funeral directors' associations and all other organizations directly contacting the people of your district. No cause ever exceeds the efforts of its leaders.

"As a test of our leadership in the Division of Vital Statistics, during the months of September and October this year we checked some 2500 birth certificates for school enrollment, which births occurred in 1928, coming from every county in the state. We were unable to find 143 of these records. A closer check revealed that 114 of the missing certificates belonged to only five counties in the state, with one county being responsible for 61 missing records, and I will exclude from these five counties our five most populous counties: Cuyahoga, Hamilton, Lucas, Franklin and Montgomery.

"For many years I have watched the improvement of registration in the respective counties and I know what a health commissioner means to this work. You should acquaint yourself with the smallest item that goes on a birth and death certificate, as each one is there for a purpose. When a single item is neglected or reported inaccurate, it involves much additional expense and effort."

The transportation of human dead bodies, filing of stillbirth records, methods of checking birth registrations, nonresident births and deaths, data on occupation requested on death certificates, etc., were discussed briefly by Mr. Plummer.

In conclusion he called attention to the importance of the medical certificate of death.

"This is most important in the compilation of mortality statistics," he said. "Each physician should have at his command the Physician's Pocket Reference to the International List of Causes of Death as a guide in giving the principal causes of death, related cause of importance, and contributory causes of importance, making mortality information uniform throughout the state.

"From the medical certificate of death we collect information which proves the value of medical research and education along the lines of pre-

ventive medicine and also safety campaigns for the prevention of accidents. This information is used to maintain better health, which is sufficient evidence for the necessity of accurate vital facts."

* * *

Dr. Joseph W. Mountin, surgeon, U. S. Public Health Service, spoke on "Public Health Administration Under the County Government Amendment".

Dr. Mountin was sent to Ohio by the U. S. Public Health Service to assist the Governor's Commission on Reorganization of County Government in formulating suggestions for reorganizing public health administration in counties adopting new forms of county government under the County Home Rule Amendment adopted at the general election in 1933.

Dr. Mountin said that there are three methods which might be used in establishing public health administration, namely: To centralize all public health work in a state department; permit each political subdivision to have its own public health service; or moderate consolidation of health services with the county as the unit. He stated that the latter plan is the one favored by the Governor's Commission.

Dr. Mountin emphasized the importance of maintaining the public health department under any county-unit plan as an independent, responsible department, comparable to any other important department of county government, and stressed the necessity for quality of personnel.

It was pointed out by Dr. Mountin that the Governor's Commission had not completed its final recommendations but that it favored a plan which would authorize the appointment of the county health commissioner by the chief executive or chief executive board of the county upon the advice and consent of a board of health which would have legislative power and advisory authority in matters of policy and procedure. He said that such county health department could gradually take over the powers and duties of the present district and city health departments, consolidating all the health work of the county in one department.

* * *

Among other subjects discussed at the conference were:

"Feeding Garbage to Hogs", by Dr. H. H. Pansing, health commissioner of Montgomery County. Dr. Pansing cited the public health problem which has arisen in his county from the distribution of city garbage to hog farms and the methods used to control this menace to health.

"Sealing of Abandoned Coal Mines", by B. F. Hatch, sanitary engineer, State Department of Health.

"The Milky Way", Dr. H. S. Allen, health commissioner of Ironton, and "Milk Sanitation", by M. J. Dotter, district supervisor of rural sanitation, U. S. Public Health Service, detailed reviews of the need for and methods used in safeguarding milk supplies.

"Rural Sanitation in Ohio", by Dr. W. P. Johnson, assistant director of rural sanitation, State Department of Health, who summarized the work being done under the FERA in rural sections of Ohio.

"Well Development", by B. V. DeVier, sanitary engineer, State Department of Health.

"Problems of Public Health Nursing", Miss Helen L. Felkner, R.N., field nursing representative, State Department of Health. Miss Felkner discussed the qualifications of the public health nurse, regulation of the field of public health nursing, professional relations, programs of public health nursing, and standards for that field of activity.

* * *

During the conference, the Ohio Federation of Public Health Officials held several business sessions.

Dr. W. G. Rhoten, Wooster, health commissioner of Wayne County, was elected president for the ensuing year, succeeding Dr. G. T. Wasson, health commissioner of Crawford County. Dr. Alfred G. Sturgis, health commissioner of Washington County, was elected vice president, and Dr. W. D. Bishop, health commissioner of Darke County, secretary-treasurer.

Dr. G. D. Loomis, Middletown, and Dr. R. H. Markwith, Akron, were named delegate and alternate, respectively, to the American Public Health Association.

The federation went on record favoring the introduction of legislation in the regular session of the General Assembly, providing for appropriation by the state of an amount equal to a minimum of 40 cents per capita for public health purposes, such fund to be distributed by the State Department of Health to the various health districts to supplement local funds for public health administration. The federation recommended that the State Department of Health be authorized by statute to set up minimum standards of public health service which must be maintained by all health districts in order to share in the state subsidy and to prevent dismissal of encumbent health officials by the State Director of Health.

* * *

Exclusive of members of the staff of the State Department of Health who were in attendance at the conference, the following county and city health commissioners, nurses, other public health workers and guests registered and were in attendance:

HEALTH COMMISSIONERS

Dr. M. D. Ailes, Akron; Dr. G. O. Rowland, Alliance; Dr. R. P. Bogniard, Ashland; Dr. James H. Park, Ashtabula; Dr. H. A. Finefrock, Barberton; Dr. A. J. McCracken, Bellefontaine; Dr. W.

G. Carlisle, Bucyrus; Dr. F. M. Sayre, Canton; Dr. Owen C. Fiske, Cincinnati; William Justus, Circleville; Dr. Harold J. Knapp, Cleveland; Dr. N. C. Dysart, Columbus; Dr. Carl W. Dewey, Conneaut; Dr. A. O. Peters, Dayton; Dr. J. D. Westrick, Defiance; G. O. Higley, Delaware; Dr. C. F. Savage, Delphos; J. D. Craig, Dover; Dr. G. W. Stober, East Cleveland; Dr. Roy C. Costello, East Liverpool; E. J. Gray, East Palestine; Dr. George E. French, Elyria; Martha Laffey, R.N., Findlay; L. W. Gibson, Fostoria; Dr. J. G. Mannhardt, Galion; Dr. R. V. Clifford, Girard; Dr. H. S. Allen, Ironton; Harry Johnson, Jackson; J. B. Holm, Kent; Kate Fulton, R.N., Kenton;

Dr. Wallace J. Benner, Lakewood; Dr. J. B. Poling, Lima; Dr. T. J. Mohn, Lockland; Dr. Valloyd Adair, Lorain; Dr. F. S. McGee, Marietta; Dr. Kenneth D. Smith, Marion; John Donovan, Martins Ferry; Dr. G. D. Lummis, Middletown; A. M. Reese, Mingo Junction; Dr. Julius Shamansky, Mt. Vernon; Dr. W. H. Hyde, Nelsonville; Dr. W. H. Knauss, Newark; Dr. C. L. Bell, Norwalk; Dr. L. O. Saur, Norwood; Dr. H. W. Lautenschlager, Oakwood; Mrs. Clara C. Wilder, R.N., Painesville; Dr. O. J. Tatje, Portsmouth; Dr. George C. Bishop, St. Bernard; Dr. R. T. Holzbach, Salem; Dr. Paul M. Spurney, Shaker Heights; Dr. O. M. Craven, Springfield; Julius A. Pizzoferrato, Steubenville; Dr. Charles Scofield, Struthers; Dr. J. A. Gosling, Tiffin; Dr. Basil B. Brim, Toledo; Dr. H. D. McCulloch, Toronto; Dr. C. A. Morgan, Van Wert; Dr. Alfred W. Veit, Wapakoneta; Dr. M. T. Knappenberger, Warren; Dr. J. S. McCulloch, Wellsville; Dr. A. D. DeHaven, Xenia; Dr. Coyt H. Beight, Youngstown; Dr. D. G. Caudy, Zanesville;

Dr. Hazel Sproull, West Union; Dr. J. J. Sutter, Lima; Dr. G. B. Fuller, Loudonville; Dr. W. S. Weiss, Jefferson; Dr. J. M. Higgins, Athens; Dr. Roy C. Hunter, Wapakoneta; Dr. W. L. Faul, Russellville; Dr. C. J. Baldridge, Hamilton; Dr. Glenn C. Dowell, Carrollton; Dr. C. E. Thompson, Urbana; Dr. R. R. Richison, Springfield; Dr. C. R. Colburn, Batavia; Dr. W. K. Ruble, Wilmington; Dr. G. T. Wasson, Bucyrus; Dr. Robert Lockhart, Cleveland; Dr. W. D. Bishop, Greenville; Dr. B. B. Barber, Delaware; Dr. F. M. Houghtaling, Sandusky; Dr. W. R. Coleman, Bremen; Dr. James F. Wilson, Washington C.H.; Dr. H. L. Mitchell, Columbus; Dr. F. W. Shane, Gallipolis; Dr. W. C. Marshall, Xenia; Dr. D. L. Cowden, Cambridge; Dr. E. H. Schoenling, Cincinnati; Dr. S. F. Whisler, Findlay; Dr. J. H. Holcomb, Kenton;

Dr. J. M. Scott, Scio; Dr. J. R. Bolles, Napoleon; Dr. John L. Walker, Hillsboro; Dr. W. B. Lacock, Logan; Dr. J. C. Elder, Millersburg; Dr. B. C. Pilkey, Norwalk; Dr. Brinton J. Allison, Jackson; Dr. J. P. Young, Steubenville; Dr. H. W. Blair, Mt. Vernon; Dr. C. B. Elliott, Painesville; Dr. Lee Traul, Bellefontaine; Dr. F. R. Dew, Oberlin; Dr. Robert Trimble, London; Dr. N. Sifritt, Marion; Dr. T. W. Mahoney, Medina; Dr. W. S. Ellis, Pomeroy; Dr. F. E. Ayers, Celina; Dr. E. R. Hiatt, Troy; Dr. H. H. Pansing, Dayton; Dr. A. O. Abraham, McConnelsville; Dr. R. L. Pierce, Mt. Gilead; Dr. Beatrice Hagen, Zanesville; Dr. G. M. Mason, Caldwell; Dr. C. B. Finefrock, Port Clinton; Dr. F. J. Crosbie, New Lexington;

Dr. C. C. Beale, Circleville; Dr. R. T. Leever, Waverly; Dr. R. D. Worden, Ravenna; Dr. J. I. Nisbet, Eaton; Dr. L. M. Piatt, Ottawa; Dr. R. E. Bower, Chillicothe; Dr. F. M. Teeple, Fremont; Dr. G. W. Fishbaugh, Portsmouth; Dr. D. W. Fellers, Tiffin; Dr. A. B. Lippert, Sidney; Dr. Floyd R. Stamp, Canton; Dr. R. H. Markwith, Akron; Dr. J. Blickensderfer, New Philadelphia; Dr. John D. Boylan, Marysville; Dr. Charles R. Keyser, Van Wert; Dr. Ed Blair, Lebanon; Dr. Alfred G. Sturgiss, Marietta; Dr. W. G. Rhoten, Wooster; Dr. W. A. Held, West Unity; Dr. H. J. Powell, Bowling Green; Dr. L. W. Naus, Upper Sandusky.

NURSES AND OTHERS

Charlotte Phelps, Circleville; Mary C. Ryan, Norwalk; Harriet Hunt, Norwalk; Charlotte E. Smith, Steubenville; Luetta Speice, Cambridge; G. L. Moore, D.D.S., Girard; Margaret G. Jones, Gallipolis; Norah D. Abbe, Elyria; Alice Squire, Oak Harbor; Katherine Fulton, Kenton; Leota McKee, West Union; Rhea Denton, Lancaster; Lenore Wheaton, Dover; Edward Croinger, Columbus; D. R. Mellon, Youngstown; Alice J. Whittier, Delaware; Mabel C. Green, Fremont; Elizabeth Moore, Zanesville; Helen D. Greene, Bryan; Pauline Baker, Madison County; Ella D. Kinne, Washington C. H.; Elizabeth Rowland, Washington C. H.; Esther I. Miller, Van Wert; Marcile Spayd, Van Wert; Betty M. Coggins, Ironton; Elizabeth P. August, Columbus; Mabel Lehman, Dayton; Helen Ranly, Miamisburg;

Alice Mitchell, Dayton; Mary W. Christy, Miamisburg; Grace E. Brady, Miamisburg; Georgia Sikes, Portsmouth; Goldia Young, Portsmouth; Ellen DeHart, Urbana; Mae L. Tisdale, Columbus; Helen Hayden, Mansfield; Miriam Wolf, Mansfield; Lucille Neldon, Newark; Fannie M. Howe, Lancaster; Flora B. Howe, Lancaster; Mary M. Miller, Troy; Clara M. Schumm, Troy; Essie Bliss, New Lexington; H. J. Swaim, Columbus; Ann Morgan, Athens; Viola M. Fell, Athens; Martha Reiter, Napoleon; Nadean G. Pace, Zanesville; Alice Keller, Zanesville; Ruth Schindler, New Philadelphia; Ruth Olson, Columbus; Helen W. Doll, Fremont; Mattie B. Pierce, Columbus; Helena Roth, Columbus; Clara F. Brouse, Columbus; Katherine Poling, Lima; Lucy E. Lynn, Portsmouth; M. Fleeta Thomas, Columbus; W. S. Gamel, Washington C. H.; R. L. Marlow, Athens; M. J. Dotter, Columbus; K. A. Lynn, Warren;

R. R. Hohl, Newark; Mabel E. Wade, Oberlin; Charity M. Sherod, Oberlin; Ruth Paddock, Oberlin; Kathryn Fulton, Elyria; M. W. Reinhardt, Tiffin; E. R. McCoppin, McArthur; Emma R. Davis, Painesville; Marie McElwee, Grandview Heights; Louise T. Tooker, Cincinnati; Myrtle Herrick, Youngstown; Adda Chambers, Canfield; Andalegne Smith, Youngstown; Elva Boyer, Sebring; Gladys Hughes Burke, Portsmouth; Helen Hart, Cincinnati; Dessie Piper, St. Clairsville; Mary Weems, Bellaire; W. J. Baldwin, Piqua; Dr. F. C. Smith, Fremont.

— OSMJ —

How industry can reduce eye casualties, with resulting tremendous savings—financial as well as human—is outlined by Dr. Walter H. Snyder, of Toledo, in a recent issue of *The Sight-Saving Review*, quarterly journal of the National Society for the Prevention of Blindness. Dr. Snyder is president of the Ohio Commission for the Blind.

— OSMJ —

Findlay—The local Kiwanis Club was addressed by Dr. Walter G. Stern, Cleveland, who defended the present system of medical practice as compared to any system under governmental administration.

OHIO SUPREME COURT AGAIN UPHOLDS THE CONSTITUTIONALITY OF THE OHIO MEDICAL PRACTICE ACT

THE extensive list of judicial opinions and decisions sustaining the constitutionality of the Ohio Medical Practice Act was augmented on November 27 when the Ohio Supreme Court dismissed error proceedings in the case of Ed Sorgen vs. State on the ground that "no debatable constitutional question is "involved". (*Ohio Bar*, December 3, 1934, page 457).

Action of the Supreme Court upheld judgments rendered by the Cleveland Municipal Court and the Court of Appeals of Cuyahoga County convicting Sorgen of conducting an office for the practice of medicine and advertising himself as engaged in the practice of medicine before obtaining a certificate to practice from the State Medical Board.

The action of the Supreme Court settled no question which had not been passed upon repeatedly by the Ohio courts. However, it will serve the purpose of adding further support to the fact that the Medical Practice Act is fair, equitable and constitutional, and should be helpful to law enforcement officials in prosecuting those engaged in the unlawful practice of medicine.

Sorgen is a "magnetic healer" whose fantastic promotional activities extended into many communities of Northeastern Ohio and who had been successful in evading conviction on numerous occasions through legal technicalities until his arrest and prosecution in Cleveland.

Counsel for Sorgen based their argument that the Medical Practice Act is unconstitutional on the contention that the section defining the practice of medicine as the performance of certain specific acts for which a "fee or compensation of any kind direct or indirect" is charged makes "an arbitrary and unjust classification" of those who engage in the healing arts into two groups: (1) those who must obtain a certificate, and (2) those who do not have to do so.

Although it submitted no written opinion on the questions raised by the plaintiff in error, the Supreme Court in dismissing the petition said, in effect, that this argument was insufficient to prove the Medical Practice Act unconstitutional.

Moreover, the court, in effect, sustained the contention of the State that "the language 'fee or compensation of any kind direct or indirect' used by the State Legislature in defining the practice of medicine or surgery in Section 1286 of the General Code intended to include the acceptance of money or other compensation for services, whether it be called a donation, free will offering, charge, fee or by any other term".

In addition, the court, in effect, upheld the argument of the State that the question of "fee or compensation" is not an element in cases involving charges of conducting an office or advertising the practice of medicine or surgery, as found in the State's brief in opposition to the motion to have the appellate court certify its record:

"The gravamen of the violation of that section of the statute which makes it unlawful to open or conduct an office, or the advertising of the giving of treatments, without first obtaining a license, is the public announcement of a general readiness and willingness to treat the sick as evidenced by the act of opening or conducting an office, or the act of advertising or announcing the giving of treatments. These offenses do not require actual treatment and therefore the question of fee or compensation become immaterial."

— OSMJ —

Court Holds Existing Statutes Prevent Diversion of Gasoline Tax For Other Than Highway Purposes

One major source of revenue for local political subdivisions in carrying on local statutory poor relief activities for which federal-state funds cannot be used under the rules and regulations of the Federal Emergency Relief Administration and the State Relief Commission was eliminated on November 27 when the Ohio Supreme Court ruled that the diversion of money raised by the excise tax on gasoline from maintenance, repair and improvement of roads to poor relief or any other purposes is illegal under existing statutes.

The decision handed down in the case of E. C. Rogers, et al., v. State, ex rel., James O. Lucas, etc. (*Ohio Bar*, December 3, 1934, page 480) will prevent townships, counties and municipalities from using their share of the gasoline tax fund for financing mothers' pensions, soldiers' relief, blind relief, burial of indigents, the operation of local welfare institutions, hospitalization of the needy, and medical care of the indigent in localities which are not receiving federal-state funds for operating the medical relief plan provided for under Rules and Regulations No. 7, FERA.

The court did not rule on the question of whether the diversion of gasoline tax money for other than highway purposes was or was not constitutional. It decided the issue on a technicality.

The decision pointed out that Amended Senate Bill No. 61, enacted by the General Assembly on February 27, 1933, authorized the expenditure of

gasoline and motor vehicle license tag funds locally for poor relief purposes.

However, on June 20, 1933, the General Assembly enacted Senate Bill 62 which amended Sections 5527 and 5541 of Amended Senate Bill 61 reducing the tax on gasoline and in which the following language contained in the original sections of Amended Senate Bill No. 61 was omitted:

"* * * and as to the tax levies between the effective date of this act and March 1, 1935, for the purpose of providing poor relief in the various counties of this state."

It was the opinion of the court that "poor relief" was therefore eliminated as one of the purposes for which gasoline tax funds may be used and that under the terms of Amended Senate Bill 62, the later expression of the intent of the Legislature, the use of gasoline tax money was specifically limited to "maintenance, repair and improvement of roads".

The decision pointed out that the use of gasoline tax funds for purposes other than those specified in the statutes levying such taxes would violate Section 5 of Article 12 of the Constitution of Ohio, namely:

"No tax shall be levied, except in pursuance of law; and every law imposing a tax, shall state, distinctly, the object of the same, to which only, it shall be applied."

The Supreme Court did not decide on the validity of the use of money raised from the sale of motor vehicle license tags for poor relief, a question considered at the time the question of diversion of gasoline tax funds was before the court, holding that a writ in prohibition to prevent diversion of motor vehicle license tax money was not the proper legal remedy. This question is expected to come before the Supreme Court later when a Hamilton County case is brought before it on appeal.

Officials of the State Relief Commission state that the decision has little effect on the activities carried on by the Commission which did not count on this source of revenue in figuring the relief needs of the state for the ensuing year.

However, they pointed out that it will greatly handicap many communities in providing statutory relief for which federal-state funds cannot be used.

In all probability the Legislature will be asked to amend the present statutes to permit diversion of gasoline tax funds for poor relief as provided in Amended Senate Bill 61 before it was again amended and reenacted.

—OSMJ—

Cleveland—Dr. Harry G. Sloan has been awarded the degree of doctor of science by Washington and Jefferson University. Dr. Sloan was a graduate of the class of 1902 and has been a trustee of the university for several years.

New Books Received

The Autonomic Diseases or the Rheumatic Syndrome, by T. M. Rivers, M.D., Kissimmee, Florida; a discussion of the autonomic nerves, their relation to certain organs and tissues of the body in health and in disease; and a definite discussion of the resulting diseases taken up separately; Dorrance & Company, Inc., Philadelphia, publishers; price $3.00.

The 1934 Year Book of General Medicine, edited by George F. Dick, M.D., Lawrason Brown, M.D., George R. Minot, M.D., William R. Castle, M.D., William D. Stroud, M.D., and George B. Eusterman, M.D.; consisting of discussions on infectious diseases, diseases of the chest, diseases of the blood and blood-forming organs; diseases of the kidneys, diseases of the heart and blood vessels, and diseases of the digestive system and of metabolism; The Year Book Publishers, Inc., 304 South Dearborn Street, Chicago; price $3.00.

Periodic Fetrility and Sterility in Woman, by Professor Herman Knaus, head of the clinic for gynecology and obstetrics, German University of Prague; foreword by F. H. A. Marshall, F.R.S., Christ's College, Cambridge, England; authorized English translation by D. H. Kitchin and Kathleen Kitchin, London; a monograph dealing with a natural method of birth control; Wilhelm Maudrich, Vienna, Austria, publisher; The Concip Company, Hobart, Indiana, American distributor; price $6.50.

Sculpture in the Living, by Jacques W. Maliniak, M.D., formerly major, reconstructive hospitals, Allied Armies, and attending plastic and reconstructive surgeon, Sydenham Hospital, New York City; foreword by Dr. Wendell C. Phillips; a presentation of the subject of plastic surgery in a simple, readable way for the general practitioner and the specialist who lack time for an exhaustive study of the subject. The Lancet Press, 80 Lafayette Street, New York; price, $3.00.

An Activity Analysis of Nursing, by Ethel Johns, R.N. and Blanche Pfefferkorn, R.N., editor of the Canadian Nurse and director of study, National League of Nursing Education, respectively; issued under the auspices of the Committee on the Grading of Nursing Schools; a study on nursing activities; aspects of nursing skill; conditions requiring nursing care, etc.; Nursing Information Bureau, American Nurses' Association, 50 West 50th Street, N. Y., publishers; price, $2.00.

Wishing Hunting in the Unconscious, Milton Harrington, M.D., psychiatrist, Institution for Male Defective Delinquents, Napanoch, N. Y.; an analysis of psychoanalysis; The MacMillan Company, 60 Fifth Avenue, New York City, publishers; price, $2.50.

CORPORATE PRACTICE OF A PROFESSION HELD ILLEGAL IN IMPORTANT RECENT DECISIONS OF OHIO SUPREME COURT

ADDITIONAL precedent and authority for prohibiting the corporate practice of medicine in Ohio were established on November 27 when the Ohio Supreme Court handed down a decision holding the formation of a corporation for the purpose of carrying on the practice of any profession and the performance of certain acts by a corporation which constitute the practice of a profession as unauthorized and unlawful.

Written by Judge Edward S. Matthias, the Court's findings brought to a close litigation originating in the Common Pleas Court of Cuyahoga County instigated by Jack B. Dworken, et al., against The Land Title Abstract & Trust Company, The Guarantee Title and Trust Co., and The Cuyahoga Abstract & Trust Company to prohibit such companies from practicing law. (*Ohio Bar*, December 3, 1934, pages 467-472).

After hearing arguments by counsel for the plaintiffs in error and considering the three cases together, the Supreme Court upheld the finding and order of the Court of Appeals of Cuyahoga County perpetually enjoining each company from performing certain practices which in the opinion of the court constituted the unauthorized and unlawful practice of law.

Since the practice of law and the practice of medicine are comparable from a professional and legal standpoint, and especially from the standpoint of the personal, confidential relationship existing between attorney and client or physician and patient, the decision is of vital importance and interest to members of the medical profession as well as members of the legal profession.

Four pertinent points emphasized by the court are summarized in the syllabus as follows:

1. The practice of law is not limited to the conduct of cases in court. It embraces the preparation of pleadings and other papers incident to actions and special proceedings and the management of such actions and proceedings on behalf of clients before judges and courts, and in addition conveyancing, the preparation of legal instruments of all kinds, and in general all advice to clients and all actions taken for them in matters connected with the law.

2. Since Section 8623-3, General Code, precludes the formation of a corporation for the purpose of carrying on the practice of any profession, a corporation is not authorized to perform acts which constitute the practice of a profession.

3. The practice of law involves a personal relation which cannot be fulfilled by a corporation, and the practice of law is confined to those who have met the prescribed requirements and have been regularly admitted to the bar.

4. The right to practice law conferred by the state is a special privilege in the nature of a franchise and a possessor thereof may be protected by injunction from the invasion of the right thus vested in him.

In support of the first proposition of the syllabus, the court declared "there is little support for the contention that the practice of law is limited to the conduct of cases in court; on the contrary it is held to have a much wider scope". Numerous court decisions in which the practice of law has been defined were cited to show the different services recognized as a part of the practice of law.

The analogy between this proposition and the definition of what constitutes the practice of medicine, as found in Section 1286, General Code, is obvious. As pointed out in the decision, the practice of law embraces more than the conduct of cases in court. Under Section 1286, General Code, the practice of medicine is recognized as a broad and inclusive professional business engaged in by a person who uses certain titles which "in any way represents him as engaging in the practice of medicine, surgery or midwifery, in any of its branches or who examines or diagnoses for a fee or compensation of any kind, or prescribes, advises, recommends, administers or dispenses for a fee or compensation of any kind, direct or indirect, a drug or medicine, appliance, application, operation or treatment of whatever nature for the cure or relief of a wound, fracture, or bodily injury, infirmity or disease".

Applying the reasoning of the court, that those engaged in furnishing any of the services recognized as a part of the practice of law without the legal right to do so are carrying on the unauthorized practice of law, to the field of medicine, it follows that any person who performs any of the services summarized in Section 1286, General Code, without the legal right to do so is engaged in the unlawful and unauthorized practice of medicine.

With respect to the right of a corporation to engage in the practice of a profession, the court was concise and definite.

"It seems too obvious to permit any discussion that a corporation may not be authorized to practice law, and hence should not be permitted to perform, or hold itself out as authorized to perform, any of the acts which constitute the prac-

tice of law. It scarcely seems necessary to cite any authority upon this proposition," the decision stated.

"Compliance with the requirements of statute and the rules of the court is a prerequisite to the practice of law. For reasons that are obvious such compliance by a corporation is impossible. ***

"In this state the formation of a corporation for the purpose of carrying on the practice of a profession is expressly prohibited by statute, Section 8623-3, General Code".

Among citations listed in support of this proposition, the court quoted from 2 Ruling Case Law, page 946, as follows:

"Since, as has been seen, the practice of law is not a lawful business except for members of the bar who have complied with all the conditions required by statute and the rules of the court, and as these conditions cannot be performed by a corporation, it follows that the practice of law is not a lawful business for a corporation to engage in. As it cannot practice law directly, it cannot do so indirectly, by employing competent lawyers to practice for it, as that would be an evasion which the law will not tolerate."

This contention also applies to the field of medicine. Since it is unlawful for a corporation in Ohio to practice medicine directly, it cannot lawfully engage in the practice of medicine indirectly through the employing of licensed physicians to practice for it.

Augmenting this conclusion, Judge Matthias quoted the following excerpt from the New York Court of Appeals decision in the case of In re Cooperative Law Co., 198 N.Y., 479, which offers a clear and comprehensive expression on the illegality and evils of corporate practice of a profession:

"The relation of attorney and client is that of master and servant in a limited and dignified sense, and it involves the highest trust and confidence. It cannot be delegated without consent, and it cannot exist between an attorney employed by a corporation to practice law for it, and a client of the corporation for he would be subject to the directions of the corporation, and not to the direction of the client. There would be neither contract nor privity between him and the client, and he would not owe even the duty of counsel to the actual litigant. The corporation would control the litigation, the money earned would belong to the corporation, and the attorney be responsible to the corporation only. His master would not be the client but the corporation, conducted it may be wholly by laymen, organized simply to make money and not to aid in the administration of justice which is the highest function of an attorney and counselor at law. The corporation might not have a lawyer among its stockholders, directors, or officers. Its members might be without character, learning or standing. There would be no remedy by attachment or disbarment to protect the public from imposition or fraud, no stimulus to good conduct from the traditions of an ancient and honorable profession, and no guide except the sordid purpose to earn money for stockholders. The bar, which is an institution of the highest usefulness and standing, would be degraded if even its humblest member became subject to the orders of a money-making corporation engaged not in conducting litigation for itself, but in the business of conducting litigation for others. The degradation of the bar is an injury to the state."

What the New York court has said regarding the evils of corporate practice of law are applicable in every respect to the practice of medicine carried on and controlled by a corporation whose sole object is to make money.

The decision upholds the use of injunction as the proper remedy in eliminating the corporate practice of a profession, declaring:

"Surely the courts are not impotent to protect those to whom the right to practice law has been granted from the natural and necessary results of the unauthorized exercise of those rights by others, whether they be corporations or individuals. It is quite generally held that the right to practice law conferred by the state is a special privilege in the nature of a franchise, and that the holder thereof may be protected from the invasion of the right thus vested in him. The adequate remedy for such invasion is by injunction, and that is so whether the transgressor is an individual or a corporation, though as to the latter, as contended, quo warranto would lie."

— OSMJ —

Department of Preventive Medicine Created at Cincinnati U.

The board of trustees of the University of Cincinnati has created a department of preventive medicine in the College of Medicine and promoted Dr. Thomas J. LeBlanc to professor of preventive medicine in charge of the new department. Preventive medicine had been a sub-department under the department of bacteriology and hygiene.

The following faculty appointments and changes were made:

Dr. Max M. Zinninger, associate professor of surgery, was named assistant dean of the College of Medicine. Dr. Joseph A. Freiberg was promoted to associate professor in orthopedic surgery. Dr. John W. McCammon was promoted to assistant professor in orthopedic surgery. Dr. Albert Faller was made professor emeritus of contagious diseases. Dr. William Machle and Dr. Lester Sanders were appointed instructors in physiology. Dr. Leon Goldman was named an assistant in dermatology. Dr. William Peake was made assistant professor of psychiatry; Dr. Francis Baurichter, part-time assistant in anatomy; Dr. Howard W. Robinson, assistant professor of pediatric research; Dr. Richard D. Bryant, assistant in obstetrics.

Dr. Laurence B. Cheneweth, professor of hygiene and director of the Student Health Service, was granted sabbatical leave.

LEGAL APPLICABILITY OF BLOOD GROUP TESTS IN PATERNITY PROCEEDINGS OR PROSECUTION FOR CRIMINAL ASSAULT

AN interesting discussion of the legal applicability of blood group tests in paternity proceedings or prosecution for criminal assault was published in the November 26, 1934, issue of *The Ohio Bar*, official publication of the Ohio State Bar Association, pages 454-455.

The resume was prepared by a committee of students of the Ohio State University, College of Law.

Because of the interesting medical angles involved and the importance of the citations carried, the article is herewith republished from *The Ohio Bar* in full:

"It has been estimated that the percentage of cases in which an innocent man has been unjustly accused of being the father of an illegitimate child is unduly high. On behalf of a client who is a defendant in a bastardy proceeding or in a prosecution for criminal assault, counsel would often welcome the opportunity of securing evidence of a scientific nature which would establish the innocence of the accused, and hence eliminate the necessity of relying upon evidence of a circumstantial nature to the extent which has been necessitated frequently in the past.

"At the present time, the possibility of increasing the practical application of results achieved by scientific investigation concerning the characteristics of blood is attracting a considerable amount of attention among certain branches of both the legal and medical professions. Human blood has been classified, as is becoming increasingly widely known, as belonging to one of four groups, depending upon the presence or absence of certain chemical substances. The presence or absence of two such substances, which accounts for the four possible combinations, gives the blood certain characteristics which remain constant, and which are transmitted from parent to off-spring in accordance with the well-established Mendelian law of heredity. On the basis of this knowledge, blood tests of the mother, the child, and the alleged father reveal in a certain percentage of cases that the man could not possibly be the father of the particular child. The only method by which one of these substances can be present in the blood of the off-spring is by inheritance from one of the parents. Consequently if the blood of the mother does not contain a substance found in that of the child, one whose blood did not contain that particular substance could not be the father of that particular child.

"In cases other than those in which the test establishes the fact of non-paternity, the result of the test is not conclusive—no more definite conclusion being possible than that the man *might* be the father of the child. The number of cases in which it is possible to establish non-paternity by this method has been estimated to be about one-third of the total number of cases tested. This computation is based upon the assumption that not only the two substances referred to as A and B, which are used for the purpose of defining the four groups into which all individuals are classed, but also that two others designated as M and N shall be taken into consideration. In a given case, the probabilities of establishing non-paternity depend upon whether the individual belongs to one of the more common blood groups or to one of those more rarely found.

"Dr. L. H. Snyder, Professor of Medical Genetics of the Ohio State University College of Medicine, has shown a considerable amount of interest in the practical application of this branch of scientific knowledge and has devoted a large amount of his time to the study and development of the technique of making these tests. At the present time he is developing other tests which it is anticipated will enable the fact of non-paternity to be established in a very high percentage of cases.

"Assuming then that it might be possible to establish the innocence of a client by the use of the blood-group test, what are the possibilities of securing a court order that such a test be made, and would any legal obstacle be encountered in the introduction in evidence of the results of such a test?

"At least three Ohio trial courts have encountered the first of these questions and each has decided in favor of the propriety of granting such an order. On Feb. 6, 1934, a blood test was made as ordered by the Court of Common Pleas, Pickaway county, Ohio, on motion of counsel for defendant in the case of *State, ex rel. Jones* v. *Dern* (No. 17106). In *State, ex rel. Mae Mitchell*, v. *Lester Baker* (No. 27554), Judge Slabaugh of the Court of Common Pleas, Licking county, Ohio, granted such an order on Feb. 13, 1934. A similar order has been granted in a criminal case by Judge Thomas of the Vinton county court.

"The first case was settled out of court after the test was made. In the other two cases, the test revealed that the defendant might have been the father of the child and evidence of the result was not offered by either side at the trial. Dr. Snyder conducted the test in each case.

"The action of the trial court in these cases appears to be in harmony with a decision of the Supreme Court of Ohio. In *S. S. Kresge Co.* v. *Trester*, 123 Ohio St., 383, 175 N. E., 611 (1931), the court held a trial court has the power to require a plaintiff in a personal injury action to submit to a reasonable physical examination in order that the nature and extent of injuries may be ascertained.

"Outside of Ohio, two courts have dealt with this problem. The status of each case at the present date is to the effect that an order of this type is not proper. In *State* v. *Damm* (S.D., 1933), 252 N. W., 7, the Supreme Court of South Dakota held that it was not an abuse of discretion for a trial court in a criminal prosecution for rape to refuse to order a blood test to be made. However, a rehearing was granted by the court on Feb. 7, 1934, further developments not appearing at the date of publication. The New York Supreme Court in *Beuschel* v. *Manowitz*, 151 Misc., 899, 271 N. Y. S., 277 (1934), held that an order at the request of defendant subjecting plaintiff and her child to blood group tests should be granted; but

this decision was reversed by the Appellate Division in 272 N. Y. S., 165 (1934).

"Recent literature concerning this topic is quite extensive. Dr. Snyder has written a book, "Blood Grouping in Relation to Clinical and Legal Medicine," which is the standard text upon the subject in all English speaking countries. Legal periodical articles and notes include: "Evidence —Admissibility of Blood-Group Test," 32 Mich. Law Review, 987 (May 1934); "Admissibility in Evidence of Results of Landsteiner Blood Grouping Tests," 43 Yale L. J., 651 (Feb. 1934); "Criminal Law—Evidence—Blood Tests," 9 Wis. Law Rev., 314 (April 1934); "The Evidential Value of Blood Tests," 1 U. of Chi. Law Rev., 798 (May 1934); "Evidence—Admissibility of Blood Group Tests to Establish Non-Parentage," 82 U. of Pa. Law Rev., 654 (April 1934); "The Chances of Establishing Non-Paternity by Blood-Grouping Tests," 20 Jour. Amer. Inst. of Crim. Law, 360 (1929); "Blood Tests for Paternity," 12 A. B. A. J., 441 (1926); "The Four Blood Groups in Evidence," 76 Solicitors' Jour., 138 (1932); "Bernstein Blood Test as Evidence," 66 Irish Law Times, 111 (1932).

"In regard to whether there would be any objection to the introduction in evidence of the results of such a blood test, no Ohio decision has been discovered. The only case encountered bearing upon that point is a criminal bastardy action brought in Pennsylvania. Expert testimony based upon blood tests was given in evidence to show that the defendant could not have been the father of prosecutrix's child. The jury disregarded the evidence, found the defendant guilty, and the trial court sustained the verdict. The county court reversed the decision upon appeal and granted a new trial upon the ground that, in view of the uncontroverted expert testimony based on scientific knowledge, the verdict was not supported by the evidence. *Commonwealth* v. *Zamoralli*, 17 Pa. D & C., 229 (1931).

"In the ordinary case of this character, it would appear that no very substantial objection could be offered to the introduction of evidence of this nature. Consequently, an improvement is made possible in the conduct of cases of this character by the availability of a new type of evidence."

WORKMEN'S COMPENSATION

Digest of Recent Court Decisions and Excerpts of Interest to Physicians Pertaining to Industrial Commission Cases and Administrative Procedure.

Note: Starting with this issue, The Journal will publish from time to time under the above heading, abstracts of court decisions, legal interpretations and administrative rulings relating to claims filed with the State Industrial Commission which are of special interest from a medical viewpoint.

AN employe, suffering from a nervous breakdown as a result of overtime employment in violation of statutes regulating the employment of women and minors, cannot sue the employer for liability providing he has complied with the provisions of the Ohio Workmen's Compensation Law, the Ohio Supreme Court held recently in reversing the judgment of the appellate court in the case of *Mably & Carew Co.*, v. *Lee*, No. 24660, G.S.R. 3839.

The suit was filed by Marguerite Lee, a minor, against the Mably & Carew Company. The petition alleged that her health had become impaired as a result of overtime employment. The court of appeals held that if she could prove her claims she was entitled to recover damages from her employer. The decision intimated that if a disease were contracted or a disability sustained as the result of employment, the disabled employe might sue the employer unless the disability was covered by the Workmen's Compensation Law and the claim admitted by the State Industrial Commission.

The Supreme Court in reversing the decision of the lower court cited the provisions of Section 35, Article 2 of the Ohio Constitution, holding that section specifically prevented suits of this nature and relieves the complying employer of liability at common law or by statute.

The court stated in its opinion:

"It is readily apparent that the present amendment provides a new and comprehensive definition of the rights and liabilities of employers and employes. Under it certain new rights were created and some former ones were abolished. The amendment has become an integral part of the organic law of this state, and consequently neither the Legislature nor this court can narrow or broaden its terms."

The decision would seem to establish a precedent for the dismissal of suits against employers who comply with the provisions of the Workmen's Compensation Law by employes suffering disabilities which are not within the meaning of the term "injury" or among the disabilities found in the occupational disease schedule.

* * *

A person who applies to a municipality for relief and is given the opportunity, and required, to work for the support which he is to receive and

who, in response to such opportunity and requirement, works in one of the municipal departments at a regular daily wage, payable in groceries or in cash, is in the service and is an employe of the municipality and if injured while engaged in such work is entitled to the benefits of the Ohio Workmen's Compensation Act.

This was the judgment rendered by the Ohio Supreme Court on November 27 in the case of Industrial Commission, v. Robert McWhorter, appealed on error from the Court of Appeals of Franklin County, (*Ohio Bar*, December 3, 1934, page 480).

In 1932, McWhorter, a resident of Columbus, applied to the Division of Charities of the City of Columbus for relief. He was given a job under the supervision of the Division of Street Cleaning Refuse Collection and was paid on alternate weeks in cash and grocery orders.

While engaged in this work, McWhorter was injured and filed a claim with the State Industrial Commission for compensation and payment of medical bills.

The State Industrial Commisison rejected the claim, contending McWhorter was not an employe of the City of Columbus. The Franklin County Common Pleas Court reversed the ruling of the Commission, which judgment was sustained by the appellate and Ohio Supreme Court.

Citing the provisions of Section 1465-61, General Code, which is a part of the Workmen's Compensation Act, the Supreme Court said:

"It seems to this court that such language is broad enough to cover an indigent workman who applies to a city for relief and is required to perform labor to the value of the relief afforded, under the direction of a city authority having charge of such labor and who is credited for such labor at the same rate allowed to other laborers even though he is carried as a 'relief worker' on a separate payroll and paid out of a special fund created by 'bonds for poor relief' as provided for in Section 2294-1 to 2294-13, General Code."

The decision in the McWhorter case, it is said, will facilitate settlement by the State Industrial Commission of several hundred similar cases throughout the state which have been pending, awaiting final outcome of the McWhorter case.

The McWhorter decision applies only to injury cases among indigent persons employed directly by municipalities and paid in cash or food orders from local funds.

It does not apply to persons disabled while employed on FERA Works Projects under the supervision of the State Relief Commission and financed with federal-state funds, whose medical and hospital expenses are paid from a special fund created by the State Relief Commission and who are not compensated for lost time but may be furnished direct relief by the local relief administration during the period of disability. (See May, 1934, issue *The Journal*, pages 314-317; August issue, page 529; and September issue, page 601).

* * *

The following propositions of law relating to workmen's compensation claims have been published in the Ohio Bar Association Report and are based on common pleas and appellate court decisions in various parts of Ohio:

Particles taken into the lungs of workmen which are not sharp-pointed or jagged so as to inflict physical injury, within meaning of the Workmen's Compensation Law, do not give rise to claim for compensation from insurance fund. *Wolender v. Industrial Commission, 71 Abs. 514.*

Where a workman, while employed by a warehouse company as a laborer and in course of his employment in loading freight, attempted to catch a heavy load which had slipped from his hands, and sustained an injury to his back as a result thereof, such injury was accidental within meaning of Workmen's Compensation Law. *Cavanaugh v. Industrial Commission, 17 Abs, 550.*

An employe who was engaged in loading trucks with cases of milk, and over a long period of time, developed an internal ailment from the constant striking of his abdomen with the cases as he lifted them in the usual course of his work, did not suffer an injury within the meaning of the Workmen's Compensation Law. *Industrial Commission v. Borchert, 17 Abs., 540.*

— OSMJ —

State To Aid Beneficiaries of Statutory Relief Agencies

Supplementary relief for persons who have been receiving aid under statutory provisions but not in suffiicent proportion to care for their budgetary needs will be provided by the State Relief Commission, the Commission has announced.

In accord with this policy, the Commission through its local relief administrations will provide supplemental relief to beneficiaries of such local relief funds as mothers' pensions, blind relief, aid to soldiers and sailors, and aid to the aged if such persons are in need of more relief.

The Commission's policy on the question was summarized in the following statement:

"Applicants for relief shall receive equal consideration from county relief administrations, regardless of status with other relief agencies, except that the amount of relief received by an individual shall be based upon other available resources, the amount of relief extended being the difference between the necessary amount for maintenance and the correct proportion of the amount received from other sources as determined by visitors of the family service department."

STATE BOARD EXAMS TAKEN BY 36 MEDICAL SCHOOL GRADUATES; QUESTIONS ASKED

THIRTY-SIX applicants for licenses to practice medicine and surgery, 11 applicants for osteopathic licenses and 38 applicants for limited practice certificates took the semi-annual examinations given by the State Medical Board in Columbus, December 3-6.

Among the limited practice applicants taking the examinations were 13 chiropractors, 11 mechano-therapists, 3 electro-therapists, 1 cosmetic-therapist, and 10 masseurs.

The results of the examinations will be certified at the next meeting of the Board, scheduled for January 8.

Action was taken by the Board on applications for medical and surgical licenses through reciprocity and the following issued licenses:

Charles P. Adkins, Coldwater, Emory University; Mary Allen, Cincinnati, Baylor Medical College; Archie H. Baggenstoss, Cincinnati, University of Cincinnati; Robert H. Brown, Cincinnati, Howard University; Romig E. Christian, Columbus, Meharry Medical College; Arkley A. Dalton, Cincinnati, Meharry Medical College; Donald E. Dial, Cleveland, Yale University; John R. Dickason, Grafton, University of Louisville; Harold H. Foreman, Akron, Howard University; Alfred M. Glazer, Cincinnati, University of Michigan; Richard C. Haislip, Cadiz, Rush Medical College; Hazen L. Hauman, Toledo, University of Michigan; Michael L. Kandrac, Cleveland, St. Louis University; Paul J. Lee, Loudenville, University of Louisville; Sidney L. Mendelsohn, Cincinnati, University of Louisville; Frederick H. Miller, Dayton, University of Michigan; Melvin A. Mulvania, Lima, Rush Medical College; Bristow C. Myers, Lorain, Meharry Medical College; Mark F. Osterlin, Dayton, University of Michigan; Julius Raab, Cleveland, University of Louisville; Lawrence Rayman, Toledo, Detroit College of Medicine and Surgery; Myrle D. Shilling, Ashland, University of Michigan; Ezra I. Silver, Cleveland, Detroit College of Medicine and Surgery; Edward J. Singer, Toledo, Wayne University; James A. Spencer, Cleveland, University of Michigan; Norbert A. Tillman, Lotain, St. Louis University; Lawrence H. Wagers, Hamilton, University of Tennessee; Jonathan G. Yoder, North Lima, Indiana University; Earl H. Young, Youngstown, University of Pittsburgh; Samuel R. Zoss, Cleveland, University of Michigan; Reuben H. Hamman, Waterville, University of Buffalo; Curtis F. Culp, Norwalk, Hahnemann Medical College.

The questions asked those who took the medical and surgical examinations given by the Board were as follows:

PHYSIOLOGY

1. Describe the normal emptying of the stomach and the control of the pyloric sphincter.
2. Explain the physiology of and draw the pain pathway in angina pectoris.
3. Explain the physiology of the concentration test for kidney function.
4. What are the effects of ablation of the thyroid? Why is this procedure of value in selected cases of angina pectoris?
5. Explain the physiology of—
   (a) cardiac asthma
   (b) pulmonary edema
   (c) gallop rhythm
   (d) pulsus alterans
6. Describe the origin of the impulse and its conduction in the heart.
7. How would you determine the status of the heart, as far as congestion failure is concerned?
8. Explain the physiology of edema.
9. Discuss the role of calcium in the body from the physiological standpoint.
10. Explain, physiologically, the difference between spostic and flaccid paralysis. Give an example of each.

CHEMISTRY

1. What is glycogen? In what tissue in the body is it found? What is it converted into by dilute acid?
2. What is the difference between vegetable and animal life, from a chemical point of view?
3. Into what two groups are metals divided? Name the groups of heavy metals and metals in each group.
4. What are isotonic, hypertonic and hypotonic solutions?
5. What is meant by catalytic action? Give example.

ANATOMY

1. How many layer of muscles found in the back? Name the muscles in the second layer.
2. Briefly describe the hip-joint. Name the ligaments found there.
3. Explain how the ductus communis choledochus is formed and where it empties; give length and diameter.
4. Give the origin and distribution of the internal planter artery.
5. Name the largest nerve in the body. Through what does it pass? Name its branches.

BACTERIOLOGY, PATHOLOGY & HYGIENE

1. What is meant by anaerobic bacteria and name three anaerobic pathogenic bacilli.
2. Describe the morphology of stroptococcus pyogenes and name three pathologic conditions which they may produce in the body.
3. What is meant by pyuria, hematuria, albuminuria and glycosuria? How may such conditions be recognized?
4. What is hyperglycemia, how caused and what is its significance?
5. What is arteriosclerosis and name three serious results of its presence which may occur.
6. What is the difference in the gross pathology in lobar pneumonia, broncho-pneumonia and pulmonary tuberculosis?
7. What is the blood picture in poisoning by benzol? By lead?
8. What dangers to community health may follow a drought?
9. In what ways may the general practitioner function in preventive medicine?
10. What preventive measures would you institute to control the spread of "Trench Mouth" among school children?

DIAGNOSIS

1. Define inflammation. Give signs. Differentiate the types.
2. Make differential diagnosis between—
   (a) Rabies (b) Tetany (c) Tetanus
3. Give signs and symptoms during the first thirty-six hours of intercranial injury in the new born.
4. Classify and discuss neurosyphilis.
5. Differentiate tuberculous, luetic and varicose ulcers of leg.
6. Give symptoms, signs and diagnosis of kidney sarcoma.
7. Name the indications for amputation of an extremity.
8. Differentiate between traumatic emphysema and traumatic cyanosis of neck and head.
9. Name six causes of acute enlargement of spleen.
10. Make a diagnosis of lateral sinus thrombosis.

PRACTICE

1. What is the significance and after treatment following thoracentesis and finding:
   (a) clear fluid (b) purulent fluid (c) bloody fluid.
2. Discuss the symptoms which suggest the presence of

coronary disease of the heart and outline the treatment in such a case.
3. How would you treat a case of lobar pneumonia in a young adult sick six days with signs of beginning cyanosis?
4. Give the symptoms and dangers of a chronic gastric ulcer. Discuss the indications for
(a) medical treatment (b) surgical treatment
5. Discuss tetany, symptoms and treatment.
6. Discuss the symptoms and treatment of a case of "summer diarrhea" in a child of two years.
7. Discuss the symptoms, local appearance and treatment of parasitic stomatitis.
8. Give the symptoms of locomotor ataxia in the preataxic stage and discuss the treatment.
9. In a man of middle age with a history of gradual change in disposition, forgetfulness, states of emotional depression followed by developing grandiose ideas and irritability, what would you suspect and how would you establish the diagnosis?
10. Discuss the symptoms of dysfunction of the pituitary body—
(a) hyperactivity (b) hypo-activity.

MATERIA MEDICA

1. Give therapeutic uses, dose, manner of administration and untoward effects of adrenalin.
2. Name four remedies useful in treatment of parasitic skin diseases.
3. Classify codein. Give uses and dose. Give effect of overdose.
4. Write a prescription for influenza and give therapeutic effect of each drug.
5. Name two drugs used in treatment of epilepsy and explain the action of each.
6. Explain the nausea and emesis resulting from the use of a potent digitalis preparation.
7. Name four remedies, with dose, used in the treatment of amenorrhea.
8. Give official name and dose of calomel, cascara and castor oil. What part of the intestinal tract does each act upon?
9. Tannic acid—how and for what is it used in medicine?
10. What is the action of atropin on the intestine and on the heart?

MATERIA MEDICA (Homeopathic)

1. Name the so-called tissue remedies.
2. What is a nosode? Name four of them.
3. What is the organon? Quote one passage from it.
4. What is a repertory? Name two of them.
5. Describe the action of bryonia upon the respiratory organ.
6. Compare phosphorus with bryonia as to its action on the respiratory tract.
7. How does lachesis affect the blood stream?
8. From what is Thuja derived? Describe its general action.
9. Compare nux and hydrastis in gastric derangements.
10. What are the skin symptoms of cantharis?

SURGERY

1. Name three forms of skin graft.
2. Differentiate cancer of the cervix from the following condition with which it may be confused:
(a) Eversion of the intra-cervical mucous membrane
(b) Cystic degeneration
(c) Specific ulceration
(d) Simple erosion or ulceration
(e) Scar tissue
(f) Sub-mucous uterine fibroma
(g) Hypertrophy
(h) Uterine and cervical polypi
3. Name ten different forms of hernia.
Give the coverings from without in of an incomplete indirect inguinal hernia.
4. Name all the conditions that might cause bleeding from the rectum.
5. Differentiate cerebral contusion, concussion, compression. Give, briefly, the management of the two last named.
6. Describe and differentiate the following two postoperative conditions:
(a) Acute dilation of the stomach
(b) Acute dilation of the ileus
Give treatment of each.
7. State four causes of non-union of fractures.
Give treatment of types named.
8. A man enters the hospital suffering from stab wound of left chest, mid axillary line, between sixth and seventh ribs, four inches in length and penetrating the lung to the depth of two inches; discuss the management of this patient.
9. Make differential diagnosis between traumatic rupture of the following organs:
(a) stomach (b) liver (c) spleen
Give treatment for ruptured liver.
10. What symptoms and signs would lead you to make a diagnosis of tuberculous larynx? How would you treat same?

SPECIALTIES

1. Define and differentiate astigmatism?
How is it corrected?
2. Name three factors that may cause strabismus.
3. What is the surgical significance of MacEwen's triangle?
4. What is the difference between a high and low tracheotomy?
5. What is the difference between Ludwig's angina and Vincent's angina?

OBSTETRICS

1. Give your findings in L.O.A. presentation—
(a) abdominal
(b) vaginal
(c) management in the first, second and third stages of labor.
2. Give the symptoms, treatment and management of threatened and inevitable abortion.
3. What is meant by rotation and version in obstetrics? Give your technic in each.
4. How would you determine the death of the fetus in utero?
5. What symptoms would indicate concealed hemorrhage?



John W. Chambers, M.D., Rudolph; Starling Medical College, Columbus, 1894; aged 67; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died November 10 of toxic goiter. Dr. Chambers was a native of Union County and had practiced at Rudolph since 1916, formerly at Essex and Bays. He was a member of the board of education and director of the Rudolph Bank. Surviving are his widow, two sons, one of whom is Dr. R. E. Chambers, Panama, Canal Zone; one daughter, two brothers and two sisters.

Francis M. Granger, M.D., Russell; Medical College of Ohio, Cincinnati, 1873; aged 87; member of the Ohio State Medical Association and the American Medical Association; died November 14 of heart disease. He was in active practice until his fatal illness. One nephew survives.

John L. Henry, M.D., Athens; Columbus Medical College, 1891; aged 67; member of the Ohio State Medical Association and the American Medical Association; died December 7 following a brief illness. Dr. Henry was chairman of the Athens County Draft Board during the World War; a charter member and former president of the Athens County Medical Society; and a member of the Elks, Odd Fellows, and Knights of Pythias lodges. Surviving are his widow, one daughter, one son, Dr. J. C. Henry, who was an associate of his father, and three brothers, one of whom is Dr. W. H. Henry, Middletown.

Frank E. Ireton, M.D., Bethel; Medical College of Ohio, Cincinnati, 1906; aged 55; former member of the Ohio State Medical Association and the American Medical Association; died November 24. Dr. Ireton practiced at Newtonsville before moving to Bethel. He served as health commissioner

of Clermont County for 10 years and retired from practice several years ago because of his failing health. Surviving are his widow, one son, one daughter, his step-mother, and one brother.

Hugh S. James, M.D., McArthur; Columbus Medical College, 1890; aged 69; member of the Ohio State Medical Association and the American Medical Association; died November 15 of a self-inflicted wound. Dr. James, secretary-treasurer of the Vinton County Medical Society, had been in failing health for some time. He was a former county health commissioner and a past commander of the American Legion post. Dr. James saw active service during the World War with the medical corps. His widow and one brother survive.

Clifford C. Legler, M.D., Portsmouth; University of Louisville School of Medicine, Louisville, Ky., 1908; aged 50; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died November 25. Dr. Legler, a native of Portsmouth, began practice at Huntington, West Virginia. He had practiced in Portsmouth since 1924. His mother and one brother survive.

Benjamin H. Mackall, M.D., Barnesville; Medical College of Ohio, Cincinnati, 1870; aged 89; died November 10 of infirmities of age. He was a native of Barnesville and had practiced there since graduation from medical school. Dr. Mackall was an active member of the Masonic Lodge. Surviving are several nieces and nephews.

Samuel B. McGuire, M.D., Dover; Baltimore Medical College, Baltimore, Md., 1893; aged 67; former member of the Ohio State Medical Association and the American Medical Association; died December 6 following a stroke of paralysis. Dr. McGuire had practiced at Dover for 31 years until his recent retirement. He was active in educational, political and civic affairs; a founder of the Union Hospital Association, and a past president of the Pennsylvania Railroad Surgeons' Association. Dr. McGuire served as a member of the State Senate in 1911-12. He was a member of the Masonic, Knights of Pythias and Elks lodges. Surviving are his widow and one brother.

George M. O'Neill, M.D., Cleveland; Cleveland College of Physicians and Surgeons, 1906; aged 54; former member of the Ohio State Medical Association and the American Medical Association; died November 11. Dr. O'Neill, a native of Cleveland, was a member of the Knights of Columbus and Catholic Foresters. Surviving are two sisters and one brother.

Charles F. Ring, M.D., Urbana; New York Homeopathic Medical College and Hospital, 1881; aged 80; died December 3. Dr. Ring, a native of Urbana, returned to Urbana 10 years ago following his retirement as head of Ward's Island Hospital, New York.

Lindsey W. Scott, M.D., Willard; Eclectic Medical College, Cincinnati, 1929; aged 41; former member of the Ohio State Medical Association and the American Medical Association; died November 19. Dr. Scott practiced at West Salem before locating in Willard. He was a member of the Masonic Lodge. Surviving are his widow, one daughter, and two brothers.

William R. Spooner, M.D., Fostoria; Baltimore University School of Medicine, 1899, and Toledo Medical College, 1903; aged 65; former member of the Ohio State Medical Association and the American Medical Association; died December 3 of pneumonia. Dr. Spooner had practiced at Fostoria for the past 17 years. He was a member of the Masonic Lodge. Surviving are his widow, one son, one daughter, and one sister.

Harry W. Sullivan, M.D., Cincinnati; Medical College of Ohio, Cincinnati, 1901; aged 57; died December 3. Dr. Sullivan, a native of Lima, was a member of the Knights of Pythias and Maccabee lodges. One sister survives.

Robert S. Walker, M.D., Toledo; Detroit College of Medicine, 1891; aged 64; former member of the Ohio State Medical Association and the American Medical Association; died November 12. Dr. Walker was in active practice in Toledo until 1928 when he retired spending the last few years in travel. Surviving are his widow, two sons, one daughter and one sister.

KNOWN IN OHIO

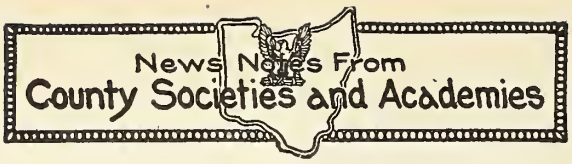
John H. French, M.D., Hartford City, Indiana; Toledo Medical College, 1913; aged 45; Fellow of the American Medical Association and a former member of the Ohio State Medical Association; died November 12 of heart disease. Dr. French practiced at Newark, Jamestown and Jeffersonville before moving to Indiana. His widow, his mother and several brothers and sisters survive.

Edward C. Ledman, M.D., Chicago; Starling Medical College, Columbus, 1903; aged 60; died December 3. Dr. Ledman practiced at Norwich before moving to Chicago. His widow, one sister and two brothers survive.

William F. Whitten, M.D., Lake Worth, Florida; Starling Medical College, Columbus, 1886; aged 72; former member of the Ohio State Medical College and the American Medical Association; died November 15. Dr. Whitten moved to Florida eight years ago from Columbus where he had practiced for many years. One daughter survives.

— OSMJ —

Green Springs—Dr. J. R. McGriff has moved to Washington, D. C., where he will specialize in eye, ear, nose and throat work.



First District

ACADEMY OF MEDICINE OF CINCINNATI

(H. J. Lavender, M.D., Secretary)

December 3—General Session. Program: "Diverticulitis and Diverticulosis of the Gastro-Intestinal Tract", Dr. Irvin Abell, profesor of surgery, University of Louisville, School of Medicine.

December 7—Joint meeting with the Cincinnati Dental Society. Program: "The Care of Injuries of the Face and Jaws", Dr. Robert H. Ivy, M.D., D.D.S., professor of maxillo-facial surgery, University of Pennsylvania.

December 10—General Session. Program: "The Use of Lipiodol in Diagnosis and Treatment", Dr. J. Forestier, Paris and Aix-Les-Bains, France.

December 17—General Session. Program: "The Treatment of Lymphogranuloma Inquinale with Vaccine and Antiserum", Dr. J. T. Tamura; discussants, Dr. E. B. Tauber and Dr. Leon Goldman. Report on Physicians' Business Bureau, Dr. Edward King. "Forty Years of Psychoanalysis", Dr. Maurice Levine; discussants, Dr. Emerson North and Dr. Thomas A. Ratliff.

Clermont County Medical Society held a dinner meeting November 21 at the Owensville M. E. Church. The speakers were Dr. William Muhlberg and Dr. Louis Feid, Jr., both of Cincinnati. At the business session, the following officers for the ensuing year were elected: President, Dr. Carl Minning, Williamsburg; vice president, Dr. C. F. Barber, Felicity; secretary-treasurer, Dr. J. M. Coleman, Loveland; legislative committeeman, Dr. James K. Ashburn, Batavia; medical defense committeeman, Dr. F. H. Lever, Loveland; delegate, Dr. Minning; alternate, Dr. Coleman.—J. M. Coleman, M.D., secretary.

Fayette County Medical Society met on December 13 at the Cherry Hotel. Following the luncheon, Dr. A. L. Van Horn, chief of the bureau of child hygiene, State Department of Health, addressed the society. The following officers for 1935 were elected: President, Dr. James M. Harsha, Washington C. H.; vice president, Dr. A. D. Woodmansee, Washington; secretary-treasurer, Dr. James F. Wilson, Washington C. H.; legislative committeeman, Dr. A. S. Stemler, Washington C. H.; medical defense committeeman, Dr. A. D. Woodmansee, Washington C. H.; delegate, Dr. E. F. Todhunter, Washington C. H.; alternate, Dr. Lucy W. Pine, Washington C. H.—James P. Wilson, M.D., secretary.

Warren County Medical Society met on November 6 at Lebanon and elected the following officers for the ensuing year: President, Dr. P. W. Tetrick, Mason; vice president, Dr. Jean A. Nock, Franklin; secretary, Dr. James H. Arnold, Lebanon; treasurer, Dr. Mary Cook, Waynesville; legislative committeeman, Dr. Henry Brown, Kings Mills; medical defense committeeman, Dr. N. A. Hamilton, Franklin; delegate, Dr. S. S. Stahl, Franklin; alternate, Dr. C. G. Randall, Harveysburg.—James H. Arnold, M.D., secretary.

Second District

Greene County Medical Society in session December 4 at Xenia elected Dr. George Davis, Xenia, as president for 1935. Other officers are: Vice president, Dr. M. M. Best, Xenia; secretary-treasurer, Dr. Reyburn McClellan, Xenia; legislative committeeman, Dr. P. D. Espey, Xenia; delegate, Dr. H. C. Messenger; alternate, Dr. C. G. McPherson. The program consisted of a round-table discussion on obstetrics.—Harold E. Ray, M.D., retiring secretary.

Miami County Medical Society elected the following officers for 1935 at its meeting December 7 at the Memorial Hospital, Piqua: President, Dr. E. G. Puterbaugh, Tippecanoe City; vice president, Dr. B. M. Hogle, Troy; secretary-treasurer, Dr. G. A. Woodhouse, Pleasant Hill; legislative committeemen, Dr. E. A. Yates, Piqua; Dr. I. C. Kiser, Piqua, and Dr. Warren Coleman, Troy; medical defense committeeman, Dr. Yates; delegate, Dr. Foster Kiser, Tippecanoe City; alternate, Dr. Hogle. A general discussion on questions of medical economics was led by Dr. Russell Gardner, Troy.—G. A. Woodhouse, M.D., secretary.

Montgomery County Medical Society was addressed on December 7 by Dr. Hugh Young, professor of urology, Johns Hopkins University, on "Tumors of the Bladder and Prostate". The meeting was held at the Dayton Biltmore Hotel and was preceded by a banquet.

On November 30, the society held a special meeting for the purpose of discussing problems of poor relief and other medico-economic problems.

Officers of the society for 1935 are: President, Dr. A. G. Farmer, Dayton; first vice president, Dr. B. F. Suffron, Dayton; second vice president, Dr. H. C. Mundhenk, Brookville; secretary-treasurer, Miss Mildred E. Jeffrey; correspondent, Dr. H. V. Dutrow, Dayton; legislative committeeman, Dr. Webster S. Smith, Dayton; medical defense committeeman, Dr. Smith; delegates, Dr. A. W. Carley, Dr. H. V. Dutrow and Dr. A. O. Peters, all of Dayton; alternates, Dr. E. M. Smith, Dr. G. L. Erbaugh, and Dr. B. F. Suffron, all of Dayton.

Preble County Medical Society in session at Eaton on November 22 elected the following officers for 1935: President, Dr. J. B. Lucas, West Alexandria; vice president, Dr. J. A. Carter, New Paris; secretary-treasurer, Dr. C. E. McKinley, Camden; legislative committeeman, Dr. A. C. Hunter, West Alexandria; medical defense committeeman, Dr. C. E. Newbold, Eaton; delegate, Dr. C. J. Brian, Eaton; alternate, Dr. C. M. Treffinger, Eaton.—C. E. McKinley, M.D., secretary.

Shelby County Medical Society has elected the following officers for the ensuing year: President, Dr. J. F. Conner, Sidney; vice president, Dr. S. C. Yinger, Sidney; secretary-treasurer, Dr. W. J. Franke, Anna; delegate, Dr. R. E. Paul, Botkins; alternate, Dr. B. A. Welch, Sidney.—S. C. Yinger, M.D.

Third District

Auglaize County Medical Society met on November 15 at Wapakoneta with 19 members present. The guest speaker was Dr. E. M. Huston, Dayton, councilor of the Second District, whose topic was "Are We Making a Good Fight?" Dr. Huston discussed present national and state movements to socialize medicine; what the medical profession is doing to combat them; and what future activities must be undertaken by the profession. Dr. C. D. Smith, Dayton, also spoke on this question, after which a general discussion was held.

The society met on December 13 at St. Marys. The program consisted of an ingenious and scientific discussion of practical, everyday interest by Dr. P. I. Tussing, Lima, on "Blood Pressure with Special Reference to Hypotension". Among those present were Drs. H. A. Thomas, E. B. Pedlow and J. C. Bradfield, all of Lima. At a business session, the society voted to add a Committee on Public Relations to the list of standing committees. Dr. Carl W. Ekermeyer, New Bremen, was admitted to membership. The following officers for 1935 were elected: President, Dr. E. F. Heffner, Wapakoneta; vice president, Dr. H. J. Gudenkauf, Minster; secretary-treasurer, Dr. C. C. Berlin, Wapakoneta; delegate, Dr. Guy E. Noble, St. Marys; alternate, Dr. R. C. Hunter; censor, Dr. G. B. Faulder, Wapakoneta; legislative committeemen, Dr. Guy E. Noble, Dr. R. C. Hunter and Dr. W. S. Stuckey, Wapakoneta; medical defense committeemen, Dr. H. S. Noble, St. Marys, Dr. T. A. Campbell, Wapakoneta, and Dr. J. E. Heap, St. Marys.—C. C. Berlin, M.D., secretary.

Hancock County Medical Society in session December 6 at Findlay elected Dr. H. O. Crosby, Findlay, president for the ensuing year. Other officers are: Vice president, Dr. W. F. Galbraith, Findlay; secretary, Dr. R. S. Rilling, Findlay; treasurer, Dr. E. J. Thomas, Findlay; legislative committeeman, Dr. E. E. Rakestraw, Findlay; medical defense committeeman, Dr. D. B. Biggs, Findlay; delegate, Dr. J. M. Firmin, Findlay; alternate, Dr. J. V. Hartman, Findlay. A paper on "Common Diseases of the Skin" was read by Dr. R. O. Ruch, Lima.—H. O. Crosby, M.D., retiring secretary.

Hardin County Medical Society was addressed on November 15 by Dr. R. W. Kissane, Columbus, on "Congestive Heart Failure".—News Clipping.

Logan County Medical Society in session December 7 at Hotel Ingalls, Bellefontaine, was addressed by Dr. A. L. Van Horn, chief, bureau of child hygiene, State Department of Health.—R. A. Firmin, M.D., secretary.

Marion County—Dr. John A. Dodd was elected president of the Marion Academy of Medicine at its meeting on December 4. Other officers elected were: Vice president, Dr. J. W. Jolley; secretary, Dr. Floyd Yeager; treasurer, Dr. D. W. Brickley; trustee, Dr. F. E. Mahla; legislative committeeman, Dr. Kenneth Smith; delegate, Dr. C. W. Sawyer; alternate, Dr. H. K. Mouser. A report submitted by Dr. Mouser, the retiring president, showed that 16 meetings had been held during 1934 with an average attendance of 59. Dr. Sawyer discussed some of the important problems confronting the academy during the coming year. —News Clipping.

Seneca County Medical Society honored Dr. R. R. Hendershott, Tiffin, president-elect of the Ohio State Medical Association, at its annual meeting on November 15 at Shawhan Hotel, Tiffin. Toasts were presented by Dr. C. D. Selby, Toledo, a past president of the State Association, and Dr. B. J. Hein, Toledo, councilor of the Fourth District. At a business session, the following officers for 1935 were elected: President, Dr. W. W. Lucas, Tiffin; vice president, Dr. R. F. Machamer, Tiffin; secretary-treasurer, Dr. R. E. Hershberger, Tiffin; legislative committeeman, Dr. George Williard, Tiffin; medical defense committeeman, Dr. E. H. Porter, Tiffin; delegate, Dr. Porter; alternate, Dr. Machamer.—R. E. Hershberger, M.D., secretary.

Van Wert County Medical Society, meeting on November 6, elected Dr. B. L. Good, Van Wert, president, and the following other officers for 1935: Vice president, Dr. W. E. Beach, Middle Point; secretary-treasurer, Dr. C. W. Morgan, Van Wert; legislative committeeman, Dr. C. R. Keyser, Van Wert; medical defense committeeman, Dr. S. A. Edwards, Van Wert; delegate, Dr. B. L. Good; alternate, Dr. Morgan.—R. H. Good, M.D., retiring secretary.

Fourth District

TOLEDO ACADEMY OF MEDICINE

(A. P. Hancuff, M.D., Secretary)

December 7—General Session at Toledo State Hospital. Program: "Mental Diseases", Dr. O. O. Fordyce, superintendent of the hospital. Clinic

and presentation of cases by members of the hospital staff.

December 14—Section of Pathology, Experimental Medicine and Bacteriology. Program: "Lead Poisoning as an Industrial Hazard and New Methods of Recognition", Dr. Paul M. Holmes; "Industrial Hazards Associated with Benzol, Toluol and Their Derivatives", Dr. C. D. Selby.

December 21 — Medical Section. Program: "Some Observations on Food Sensitization", Dr. Jonathan Forman, Columbus.

Fulton County Medical Society has elected the following officers for 1935: President, Dr. C. F. Hartmann, Wauseon; vice president, Dr. A. M. Wilkins, Delta; secretary-treasurer, Dr. George McGuffin, Pettisville; correspondent, Dr. W. H. Maddox, Wauseon; legislative committeeman, Dr. C. F. Hutchins, Delta; medical defense committeeman, Dr. C. E. Patterson, Fayette; delegate, Dr. R. W. Reynolds, Fayette; alternate, Dr. E. A. Murbach, Archbold.—George McGuffin, M.D., secretary.

Paulding County Medical Society has elected Dr. K. C. Evans, Payne, as president for the ensuing year. Other officers elected were: Vice president, Dr. E. Kohn, Grover Hill; secretary-treasurer, Dr. F. A. McCammon, Payne; legislative committeeman, Dr. R. H. Mouser, Paulding; delegate, Dr. L. R. Fast, Paulding.—G. L. Doster, M.D., retiring secretary.

Sandusky County Medical Society was addressed on November 15 at Fremont by Dr. J. L. Curtin and Dr. C. M. Harding, Bellevue. Dr. Curtin read a paper on "Hypothyroidism" and Dr. Harding spoke on "Compound Fractures".—News Clipping.

Williams County Medical Society in regular session has elected officers for the ensuing year as follows: President, Dr. E. R. Jacka, Bryan; vice president, Dr. H. L. Prouty, West Unity; secretary-treasurer, Dr. H. R. Mayberry, Bryan; delegate, Dr. W. A. Held, West Unity; alternate, Dr. H. W. Wertz.—H. R. Mayberry, M.D., secretary.

Wood County Medical Society held a dinner meeting November 15 at Bowling Green. The program was presented by Dr. R. N. Wihtehead, Dr. F. V. Boyle and Dr. T. O. Whitacre, who read papers on "Intestinal Obstruction".—News Clipping.

Fifth District

CLEVELAND ACADEMY OF MEDICINE

(C. H. Heyman, M.D., Secretary)

December 3—Pediatric Section. Program: "Experiences in the Feeding and Care of Premature Infants", Dr. Arthur J. Horesh and Dr. G. Richard Russell; "Observations on the Growth of Diabetic Children", Dr. Henry J. John.

December 4—Ophthalmological and Oto-laryngological Section. Program: Symposium on Pulmonary Abscess. "From the Viewpoint of the Internist", Dr. R. K. Updegraff; "From the Viewpoint of the Roentgenologist", Dr. E. P. McNamee; "From the Viewpoint of the Surgeon", Dr. S. O. Freedlander; "From the Viewpoint of the Bronchioscopist", Dr. Louis H. Clerf, Philadelphia.

December 5—Obstetrical and Gynecological Section. Program: "Treatment of Sterility", Dr. Paul Titus, Pittsburgh.

December 7—Clinical and Pathological Section. Program: "Some Aspects of Medicine in the Tropics", Dr. J. A. Doull. Motion picture showing activities of headquarters offices of the American Medical Association.

December 12—Practice of Medicine Section. Program: "The Newer Chemical, Bacteriological and Immunologic Concepts in Tuberculous Disease", Dr. Charles A. Doan, Columbus; "The Significance of the Alterations in the Blood Cells in Pulmonary Tuberculosis", Dr. B. K. Wiseman, Columbus.

December 14—Joint meeting of Experimental Medicine Section and Cleveland Section of Society for Experimental Biology and Medicine. Program: "Pneumolysis in the Treatment of Pulmonary Tuberculosis", Dr. S. O. Freedlander; "Note on Blood Flow in Spinal Anesthesia", Dr. C. H. Lenhart; "Studies of the Osteogenic Properties of Bone Marrow", Dr. W. H. McGaw and Dr. A. R. Moritz; "The Production of a Collateral Circulation to the Heart", Dr. C. S. Beck, Dr. V. L. Tichy and Dr. A. R. Moritz; "Results of Cabinet Fever Therapy", Dr. R. M. Stecher; "The Optic Foramen in the Dried Skull of Man", Dr. J. E. L. Keyes; "Metal Casts of the Renal Pelvis", Dr. L. N. Atlas; "Possible Application of Chemical Reactions in the Determination of Pregnancy", D. E. Bowman, B.A., J. P. Visscher, Ph.D., and J. W. Mull, Ph.D.

December 21 — General Session. Program: "Therapeutic Application of Newer Developments in Endocrinology", Dr. L. G. Rowntree, Philadelphia, director of the Philadelphia Institute of Medical Research.

Ashtabula County Medical Society met in regular session December 11 at the Broadway Inn, Geneva, and elected the following officers for the ensuing year: President, Dr. E. H. Merrell, Geneva; vice president, Dr. J. H. Park, Ashtabula; secretary-treasurer, Dr. M. R. Martin, Geneva; censor, Dr. N. C. Kiefer, Geneva.—A. M. Mills, M.D., retiring secretary.

Erie County Medical Society was addressed by Dr. Jonathan Forman, Columbus, on November 22. Dr. Forman spoke on "Allergy".—News Cliping.

Geauga County Medical Society completed a year of unusual activity, marked by excellent pro-

grams, by electing the following officers for 1935: President, Dr. Lura E. Gordon, Burton; vice president, Dr. F. S. Basquin, Chardon; secretary-treasurer, Dr. Isa Teed-Cramton, Burton; legislative committeeman, Dr. W. C. Cory, Chardon; medical defense committeeman, Dr. C. F. Gilmore, Chesterland.

On April 4, the society held a special meeting to discuss problems in connection with the FERA medical program. At a regular meeting on May 2, Dr. H. V. Paryzek, Cleveland, councilor of the Fifth District, and Dr. A. J. Skeel, Cleveland, were guests. Dr. Paryzek discussed developments in the medical relief program and the fee schedule announced by the State Relief Commission. Dr. Skeel read a paper on "Post-Partum Hemorrhage". Dr. Fred Dixon, Cleveland, addressed the society May 23 on "Mastoiditis and Middle Ear Infections". At the meeting on July 25, Dr. Julius Selman, Cleveland, was the guest speaker, discussing "Diabetes". An informal "experience" meeting was held on August 29, featured by round-table discussions. Dr. Charles LaRocco, Cleveland, was the guest speaker on September 26. His subject was "The More Common Skin Diseases". On October 31, Dr. Wallace Duncan, Cleveland, presented the subject "Arthritis". All the meetings were held at the home of Dr. and Mrs. W. C. Cory, recognized by the society as royal host and hostess.—Isa Teed-Cramton, M.D., secretary.

Lorain County Medical Society held a dinner meeting December 11 at the Elyria Memorial Hospital. It was attended by 65 members, one of the largest turn-outs in the history of the society. The following officers were elected: President, Dr. L. H. Trufant, Oberlin; vice president, Dr. George E. French, Elyria; secretary-treasurer, Dr. Zina Pitcher, Elyria; legislative committeeman, Dr. S. V. Burley, Lorain; delegate, Dr. Burley; alternate, Dr. George M. Blank. The program was presented by Dr. Leonard A. Stack, Lorain, who spoke on "Appendicitis".

At its meeting November 13 at the Hotel Antlers, Lorain, special tribute was paid to the memory of the late Dr. W. E. Hart, for many years secretary of the society. A memorial address was made by Dr. Ross Gunn, Oberlin. Dr. Burley reported on the annual meeting of the State Association and Dr. R. S. Reich, Cleveland, spoke on "Acute Septic Arthritis".—Zina Pitcher, M.D., secretary.

Medina County Medical Society has elected the following officers for the ensuing year: President, Dr. Frank C. Reutter, Spencer; vice president, Dr. T. W. Mahoney, Medina; secretary-treasurer, Dr. J. K. Durling, Wadsworth; legislative and medical defense committeeman, Dr. H. P. H. Robinson, Medina; delegate, Dr. R. L. Mansell, Medina; alternate, Dr. M. F. Miller, Wadsworth.—J. K. Durling, M.D., secretary.

Sixth District

Ashland County Medical Society held its regular meeting on December 12 at Hetter's Restaurant with Dr. O. J. Powell, retiring president, as the host. A turkey dinner was served. Dr. T. L. Bliss of the Edwin Shaw Tuberculosis Sanatorium, Akron, presented a paper on "The Collapse Treatment in the Therapy of Tuberculosis". At the business session, the following officers were installed: President, Dr. L. G. Sheets, Ashland; president-elect, Dr. George Emery, Ashland; secretary-treasurer, Dr. M. J. Thomas, Jeromesville; censor, Dr. E. L. Clem, Ashland; delegate, Dr. O. J. Powell, Ashland; alternate, Dr. Emery.

At its regular meeting on November 9, the society was addressed by Dr. K. D. Way, Akron, on "Common Allergic Problems From the Standpoint of the General Practitioner". It was extremely interesting and freely discussed.—M. J. Thomas, M.D., secretary.

Holmes County Medical Society at a dinner meeting December 5 at the Smith Hospital, Millersburg, was addressed by Dr. H. H. McClellan, Dayton.

Portage County Medical Society was entertained on December 6 at the home of Dr. E. J. Widdecombe, Kent. Dr. H. S. Davidson, Akron, councilor of the Sixth District, was present and made an interesting talk on social and economic problems confronting the profession. A paper on "Pneumatic Rupture of the Intestinal Canal" was read by Dr. John S. Deyell, Ravenna, and Dr. Edgar M. Kauffman, Kent, presented a case report. Officers for 1935 were elected as follows: President, Dr. A. M. Landsborough, Garrettsville; vice president, Dr. J. R. Turner, Kent; secretary-treasurer, Dr. E. J. Widdecombe, Kent; legislative committeeman, Dr. George J. Waggoner, Ravenna; medical defense committeeman, Dr. W. B. Andrews, Kent.—E. J. Widdecombe, M.D., secretary.

Stark County Medical Society met in regular session December 11 at the Canton Woman's Club. The guest speakers were Dr. W. B. Morrison and Dr. J. J. Coons, Columbus. Dr. Morrison discussed the subject, "Surgical Treatment of the Benign and Malignant Diseases of the Stomach and Duodenum". Dr. Coons read a paper on "Differential Diagnosis of Diseases of the Stomach".—Bulletin.

Wayne County Medical Society has elected the following officers for 1935: President, Dr. W. A. Fritz, Wooster; vice president, Dr. Jean S. Douglas, Wooster; secretary-treasurer, Dr. R. C. Paul, Wooster; delegate, Dr. Paul; alternate, Dr. R. N. Wright, Wooster.—R. C. Paul, M.D., secretary.

Seventh District

Belmont County Medical Society met in Bellaire, December 6. Dr. C. B. Messerly, Martins Ferry, spoke on the subject, "Furunculosis and Its Fre-

quent Serious Sequence". At the business session Dr. J. O. Robben, Bridgeport, was admitted to membership and the following officers for 1935 elected: President, Dr. W. L. Davis, Martins Ferry; vice president, Dr. H. E. Ring, Bellaire; secretary-treasurer, Dr. C. W. Kirkland, Bellaire; legislative committeeman, Dr. R. H. Wilson, Martins Ferry; medical defense committeeman, Dr. C. B. Messerly, Martins Ferry; delegate, Dr. W. L. Davis, Martins Ferry; alternate, Dr. E. C. Cope, Barton.—C. W. Kirkland, M.D., secretary.

Columbiana County Medical Society in session December 11 at Lisbon was addressed by Dr. John A. Fraser, East Liverpool, on "Sidelights on Post Graduate Study in Edinburgh". The following officers for the ensuing year were elected: President, Dr. Fred R. Crowgey, Salem; vice president, Dr. A. R. Cobbs, Damascus; secretary-treasurer, Dr. Guy E. Byers, Salem; legislative committeeman, Dr. Seward Harris, Lisbon; medical defense committeeman, Dr. Harry Bookwalter, Columbiana; delegate, Dr. John A. Fraser, East Liverpool; alternate, Dr. P. C. Hartford, East Palestine.—Guy E. Byers, M.D., secretary.

Jefferson County Medical Society has elected the following officers for 1935: President, Dr. Howard H. Minor, Steubenville; vice president, Dr. Walter A. Cunningham, Steubenville; secretary-treasurer, Dr. John Y. Bevan, Steubenville; legislative committeeman, Dr. A. Jacoby, Steubenville; medical defense committeeman, Dr. A. E. Weinstein, Stubenville; delegate, Dr. S. A. Harris, Steubenville.—John Y. Bevan, M.D., secretary.

Tuscarawas County Medical Society held its annual meeting December 13 at the Twin Hospital. Officers were elected as follows: President, Dr. R. J. Foster, New Philadelphia; vice president, Dr. R. D. Hildebrand, Newcomerstown; secretary-treasurer, Dr. Clark M. Dougherty, New Philadelphia; legislative committeeman, Dr. J. A. Mccollam, Uhrichsville; medical defense committeeman, Dr. E. D. Moore, New Philadelphia; delegate, Dr. W. H. H. Curtiss, Dennison; alternate, Dr. George L. Sackett, New Philadelphia.—Arthur Huston, Jr., M.D., retiring secretary.

Eighth District

Athens County Medical Society entertained the members of the Hocking County Medical Society at its meeting December 3 at Nelsonville. The guest speaker was Dr. W. H. Miller, Columbus, who spoke on "The Use of the *X*-ray in General Practice". Officers elected by the Athens County society for the ensuing year are: President, Dr. W. B. Howe, Nelsonville; vice president, Dr. John C. Henry, Athens; secretary-treasurer, Dr. T. A. Copeland, Athens; censor, Dr. John R. Sprague, Athens; delegate, Dr. C. S. McDougall, Athens; alternate, Dr. A. L. Pritchard, Nelsonville.—T. A. Copeland, M.D., secretary.

Fairfield County Medical Society held a luncheon meeting November 27 at the Hotel Martens, Lancaster. Dr. F. W. Harrah, Columbus, was the guest speaker.—News Clipping.

Guernsey County Medical Society held a luncheon meeting December 6 at the Berwick Hotel, Cambridge, when the following officers for the ensuing year were elected: President, Dr. C. A. Craig, Cambridge; vice president, Dr. B. A. Souders, Cambridge; secretary-treasurer, Dr. Reo M. Swan, Cambridge; correspondent, Dr. O. R. Jones, Cambridge; legislative committeeman, Dr. W. L. Denny, Cambridge; medical defense committeeman, Dr. Denny; delegate, Dr. G. F. Swan, Cambridge; alternate, Dr. A. G. Ringer, Cambridge. Following the business session, relief problems were discussed.—O. R. Jones, M.D., correspondent.

Ninth District

Gallia County Medical Society in session December 5 elected the following officers for 1935: President, Dr. Ella G. Lupton, Gallipolis; vice president, Dr. W. Lewis Brown, Gallipolis; secretary-treasurer, Dr. Milo Wilson, Gallipolis; legislative committeeman, Dr. S. L. Bossard, Gallipolis; medical defense committeeman, Dr. Leo C. Bean, Gallipolis; delegate, Dr. Mary L. Austin, Gallipolis; alternate, Dr. Otto O. Vornholt, Gallipolis.—Milo Wilson, M.D., secretary.

Jackson County Medical Society in session December 11 at Jackson was addressed by Dr. H. H. McClellan, Dayton.—News Clipping.

Lawrence County Medical Society held its annual dinner meeting December 6 at Hotel Marting, Ironton. An address on "Tuberculosis" was made by Dr. Harry Rapp, Portsmouth. The following officers for 1935 were elected: President, Dr. Ralph Massie, Ironton; vice president, Dr. C. E. Vidt, Ironton, and secretary-treasurer, Dr. Wilson Lynd, Ironton.—News Clipping.

Scioto County—The annual banquet of the Hempstead Academy of Medicine was held December 10 at Hotel Hurth, Portsmouth. Following a turkey dinner and program of entertainment, announcement was made of the election of the following officers for 1935: President, Dr. R. P. Elder, Portsmouth; vice president, Dr. H. P. Pearson, Portsmouth; secretary-treasurer, Dr. William E. Scaggs, Portsmouth; legislative committeeman, Dr. J. S. Rardin, Portsmouth; medical defense committeeman, Dr. A. L. Test, Portsmouth; delegate, Dr. G. R. Micklethwaite, Portsmouth; alternate, Dr. C. M. Fitch, Portsmouth.—William E. Scaggs, M.D., secretary.

Tenth District

COLUMBUS ACADEMY OF MEDICINE

(J. H. Mitchell, M.D., Secretary)

December 3 — General Session. Program: "Changes in Surgery of Brain Tumors Based on

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Twenty-Five Years Experience", Dr. Ernest Sachs, Washington University School of Medicine, St. Louis.

December 10—Annual meeting. Addresses of retiring officers and reports.

December 17—Annual Dinner, Faculty Club, Ohio State University. Address, "The Insanities of the Great Men of History", Dr. Louis J. Karnosh, Cleveland.

Crawford County Medical Society held its annual dinner meeting and election of officers December 10 at the Hotel Elberson, Bucyrus. The guest speakers were Dr. S. J. Goodman, Columbus, councilor of the Tenth District, who spoke on "Toxemias of Pregnancy", and Dr. E. F. McCampbell, Columbus, whose subject was "Treatment of Diabetes". The following officers were elected: President, Dr. Mart L. Helfrich, Galion; vice president, Dr. R. M. Malone, Galion; secretary-treasurer, Dr. Charles J. Griebling, Galion; correspondent, Dr. C. A. Lingenfelter, Bucyrus; legislative committeeman, Dr. W. G. Carlisle, Bucyrus; medical defense committeeman, Dr. Helfrich; delegate, Dr. D. G. Arnold, Bucyrus; alternate, Dr. W. L. Yeomans, Bucyrus.—C. A. Lingenfelter, M.D., correspondent.

Delaware County Medical Society has elected officers as follows for 1935: President, Dr. J. K. James, Delaware; vice president, Dr. Bruce Barber, Delaware; secretary-treasurer, Dr. William E. Borden, Delaware; legislative committeeman, Dr. C. F. Talley, Powell; delegate, Dr. D. S. Cowles, Ostrander; alternate, Dr. A. R. Callander, Delaware; medical defense committeeman, Dr. Talley.—J. G. Parker, M.D., retiring secretary.

Morrow County Medical Society, following a dinner meeting December 4 at the Globe Hotel, Mt. Gilead, was addressed by Dr. George I. Nelson, Columbus, on "Heart Conditions". At the business session the following officers were elected: President, Dr. C. E. Sherman, Cardington; vice president, Dr. C. S. Jackson, Mt. Gilead; secretary, Dr. T. Caris, Mt. Gilead; treasurer, Dr. R. L. Pierce, Mt. Gilead; legislative committeeman, Dr. Pierce; medical defense committeeman, Dr. F. Sweeney, Mt. Gilead; delegate, Dr. F. M. Hartsook, Cardington; alternate, Dr. J. P. Ingmire, Mt. Gilead.—T. Caris, M.D., secretary.

Pickaway County Medical Society in session December 7 at Berger Hospital, Circleville, was addressed by Dr. H. H. McClellan, Dayton.—News Clipping.

—OSMJ—

Dayton—Dr. W. J. Blackburn is the new president of the eye, ear, nose and throat section of the Montgomery County Medical Society. Other officers are: Vice president, Dr. H. B. Harris; secretary, Dr. F. J. Driscoll.

NEWS NOTES of OHIO

Cincinnati—A farewell dinner was held December 11 at the Hotel Netherland Plaza honoring Dr. Arthur C. Bachmeyer, former dean of the College of Medicine, University of Cincinnati, and former superintendent of the Cincinnati General Hospital, who has become director of clinics and associate dean of the College of Medicine, University of Chicago.

Wooster—Dr. R. C. Paul has moved his office from 147 North Market Street to 119 East North Street, where he has converted a dwelling into a well-appointed office suite.

Marion—Dr. A. William Chernoff, formerly of Cleveland and Boston, has opened offices here.

Columbus—Dr. Fred Hall recently returned from a trip to Canada on which he visited Callendar, Ontario, where he viewed the famous Dionne quintuplets.

Cincinnati—Dr. Gustav Eckstein, member of the faculty of the College of Medicine, University of Cincinnati, and author of the novel, "Kettle", has been awarded the $500 Sachs prize for 1933, awarded annually to the Cincinnatian with the outstanding achievement in the fields of art, music, science, literature, education, sculpture, or reesarch.

Cleveland—Announcement has been made of the marriage of Miss Jane Halle and Dr. George W. Crile, Jr., both of Cleveland.

Bethesda—Announcement has been made of the marriage of Miss Martha W. Talbott, Ellsworth, and Dr. Robert H. McKelvey, of this place, formerly of Youngstown.

Martins Ferry—Dr. R. H. Wilson addressed the local American Legion post on observations made during a recent European trip.

Mentor—Announcement has been made of the marriage of Miss Lenora Rempes, Cleveland Heights, and Dr. Howard Stevens, Mentor.

Springfield—Dr. J. E. Burgman and Dr. Joseph A. Link are taking post-graduate work in Vienna.

CLASSIFIED ADVERTISEMENTS

Rates for advertisements under this heading are 50 cents per line, payable in advance. Minimum charge of $1.00 for each insertion. Price covers the cost of remailing answers. Forms close 16th of the month preceding publication.

For Sale—Office Equipment of deceased physician in village of Cumberland, Ohio. For particulars, write R. H. L., care *Ohio State Medical Journal*.

For Sale—Physician's practice; equipment including X-ray, diathermy lamps, etc. Communicate with Mrs. L. W. Scott, 110 Dale Ave., Willard, Ohio.

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Prompt and Full Report

Causes of Death Are Not Most Frequent Causes of Illness, Federal Study Reveals

Causes of illness, as distinct from mortality statistics and data on communicable diseases, is the subject of a study just completed by the United States Public Health Service. The survey, reviewed by the senior statistician, Selwyn D. Collins, covered conditions in 8,758 white families in 130 localities in 18 states, under observation for illness for a period of 12 consecutive months between February, 1928, and June, 1931.

"The important causes of death are not the most frequent causes of illness", comments Senior Statistician Collins, in explaining why the survey was undertaken. "The mortality picture that can be painted in considerable detail does not adequately or properly represent the sickness situation."

An illness rate of 850 per 1,000 persons was determined. Illness that caused loss of time from work, schools or other occupations amounted to 516 per 1,000 persons. Illness in which the patient was confined to bed for one or more days amounted to 434 per 1,000.

MINOR RESPIRATORY CONDITIONS

Minor respiratory conditions are the most frequent causes of illness. Three of the four most frequent specific causes of illness are respiratory.

For conditions other than respiratory, accidental injuries head the list, and indigestion and other stomach disorders come next to respiratory conditions among diseases exclusive of accidents. Next to indigestion but with considerably smaller rates come measles, confinements, and ear diseases, with almost identical rates for the three.

As the survey is based solely on the frequency of cases, serious conditions like pneumonia, heart diseases, kidney diseases, appendicitis, etc., fall far down in the list. The study does not show the seriousness of a case but merely the frequency with which it occurred.

With respect to the incidence of the communicable diseases of children, such as measles, 24.4 per 1,000, whooping cough, 19.2 per 1,000, etc., observes Senior Statistician Collins, a 12-month record ordinarily would not give any indication of the expected frequency of such conditions, because they vary widely from year to year.

In the list of diseases with a rate of 23 per 1,000 is a group of rheumatic and neuralgic conditions. Technically, the diagnoses included in this category differ a great deal, but it was felt that as reported by lay persons the most accurate statement of their frequency would be obtained by combining similar aches and pains into one group.

ACCIDENTS AS CAUSE OF ILLNESS

In spite of the usual designation of "minor" respiratory diseases, the three most frequent diagnoses for disabling illness and for illness

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with one or more days in bed are in the minor respiratory class. The fourth most frequent disabling condition is accidents; but in terms of cases in which the patient was in bed, this cause is exceeded by confinements.

Indigestion, measles, and tonsil and adenoid operations are the other three diagnoses with rates for disabling cases above 20 per 1,000, with the next rate, ear and mastoid conditions, at 13 per 1,000.

Colds and bronchitis are coupled as specific diseases causing the largest amount of illness, with an annual incidence of 158.1 per 1,000. Influenza and grippe, with a rate of 86.1, is next in order of frequency.

Accidental injuries are rated at 74.7, in third place; fourth place is given to tonsillitis, laryngitis, and throat diseases, excluding tonsillectomy, with a rate of 53.4. Next is gastritis, indigestion and other stomach conditions, rated at 41.7 per 1,000.

Measles, rated 24.4, is next in order of frequency, followed by confinements, miscarriages, and abortions, with an annual frequency of 23.6 per 1,000. Ear and mastoid diseases are rated at 23.5.

Rheumatism, neuralgia, neuritis, lumbago, myalgia, etc., are nervous troubles coupled together at a rate of 22.7. Tonsil and adenoid operations rate 21.8 per 1,000.

A rating of 21.5 is recorded for diarrhea and enteritis. Next, with a rate of 19.2, is whooping cough. Nonvenereal diseases of the genital organs rate 17.5. Chickenpox has a frequency of 15.5 per 1,000.

Diseases of the heart, arteriosclerosis and high blood pressure account for 13.5 cases of illness annually in a group of 1,000 persons. Mumps occur 12.1 times. Eye diseases have a ratio of 11.6; teeth and gum conditions, 11.6; furuncles and abscesses, 11.6, and sinusitis, 10.2.

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Tuberculosis of all forms, including suspected, 4.7; eczema, 4.2; anemia in all forms, 3.8; impetigo, 3.7; thyroid diseases, 3.5; malaria ,3.4; benign tumors, 3.3; childbirth lacerations and displacement of the female organs, 3.1; pleurisy, 3.

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by M. J. ROSENAU, Professor of Preventive Medicine and Hygiene, Harvard Medical School.

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In 17 general type classifications of illness sustained, the following rates of incidence per 1,000 persons were calculated:

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HOSPITAL NOTES

—Mrs. Loucile Brick, Columbus, has been appointed secretary in charge of the state headquarters office of the Ohio Hospital Association, located in the A.I.U. Tower, Columbus. Mrs. Brick was formerly secretary to State Director of Agriculmture Earl H. Hanefeld and previous to that was secretary to former highway directors, Robert Beightler, George S. Schlessinger and Harry J. Kirk.

—Dr. E. A. Baker, Clyde, has been elected president of the Fremont Memorial Hospital staff. Other officers are: Vice president, Dr. J. L. Curtin, Fremont, and Dr. F. M. Teeple, Fremont, secretary.

—Dr. R. R. Richison is the new president of the staff of the Springfield City Hospital. Dr. H. B. Martin is vice president, and Dr. Will P. Ultes, secretary. Dr. E. J. Oesterlin, formerly of Milwaukee, has been appointed full time pathologist at the hospital, succeeding Dr. C. G. Kingry, resigned.

—The ophthalmic-pathologic unit of the Christian Holmes Hospital, Cincinnati, was dedicated recently. The unit was equipped and endowed by Mrs. Christian R. Holmes.

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Crawford	M. L. Helfrich, Galion	C. J. Griebling, Galion	1st Monday, monthly.
Delaware	J. K. James, Delaware	W. E. Borden, Delaware	1st Tuesday, monthly.
Franklin	E. G. Horton, Columbus	Drew Davies, Columbus	1st four Mondays, monthly.
Knox	E. V. Ackerman, Fredericktown	R. L. Eastman, Mt. Vernon	Last Thursday, monthly.
Madison	R. W. E. Irwin, Mt. Sterling	F. A. Lutz, Mt. Sterling	4th Wednesday, monthly.
Morrow	C. E. Sherman, Cardington	T. Caris, Mt. Gilead	Last Thursday, monthly.
Pickaway	R. S. Hosler, Ashville	E. R. Austin, Circleville	1st Friday, monthly.
Ross	O. P. Tatman, Chillicothe	W. C. Breth, Chillicothe	1st Thursday, monthly.
Union	P. D. Longbrake, Marysville	H. E. Stricker, Marysville	2d Tuesday, monthly.



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PUBLIC HEALTH - SOCIAL WELFARE MEDICAL ECONOMICS and ORGANIZATION PROBLEMS

With Editorial Comment by D.K.M.

It is earnestly hoped that every physician will read carefully and critically two articles, dealing with several medical and health questions and issues of major importance, published elsewhere in this issue of *The Journal*, namely:

Articles of Interest In This Issue

"Catechism on Sickness Insurance", pages 133 to 137.

"Changes in Local Health and Welfare Set-Ups and Coroner System Suggested by Commission on County Government", pages 138 to 143.

Needless to say, in the light of present trends and developments, well-known to every physician, it is more essential now than ever before that every member of the medical profession be thoroughly and accurately informed on economic and social questions affecting scientific medicine, medical practice, public health, etc.

Moreover, he must be well-informed on the important aspects of proposals to change the present system of distributing medical care; the merits or demerits of such proposals; and the probable good or bad effects of each if put into operation.

Unless he is informed, the physician cannot intelligently discuss these questions with his colleagues, his patients and his friends and acquaintances among the laity.

As all physicians know, serious problems, calling for wise and concerted action on the part of the medical profession, have arisen as a result of the campaign now under way to bring about in this country the complete socialization of medical practice; the establishment of a gigantic system of sickness insurance under governmental control and partially financed from public funds; or place in operation unsound and commercialistic schemes of distributing medical service to a large part of the population.

In recent months, much publicity has been given to plans already formulated or contemplated to establish some system of compulsory sickness insurance, either on a national or state-wide basis.

In order that Ohio physicians may be better informed on the defects in and objections to this mechanism, proposed to distribute the economic burden of sickness, *The Journal* in this issue is publishing a "Catechism on Sickness Insurance", prepared and originally published in pamplet form by the Bureau of Medical Economics, American Medical Association.

This brochure raises pertinent questions. The answers are brief but to the point. It furnishes the physician with data which should be useful to him when interrogated by those seeking informa-

New Sales Tax Law Regulations of Interest to Physicians Summarized

EVERY physician will be interested in, and should read carefully, an analysis of the first and tentative regulations issued by the State Tax Commission pertaining to the new Ohio Retail Sales Tax Act, published elsewhere in this issue of *The Journal*.

Most of the regulations promulgated to date by the Tax Commission are general in scope and cover the usual type of commercial transactions.

They do, however, interpret the sales tax law as specifically exempting from the tax "charges for professional or personal services which involve sales of inconsequential elements for which no separate charges are made".

Under this interpretation and regulation, when services are rendered by a physician for a professional fee and when no separate charge is made for medicine, material, appliances, etc., furnished by the physician as an incidental part of his professional service, a tax need not be collected by the physician on such tangible materials.

Doubtless, the Tax Commission will as soon as possible issue permanent regulations, clarifying and supplementing the tentative regulations.

As additional rulings and interpretations are made, especially any having a bearing on professional or personal services, they will be published and analyzed in *The Journal*.

For the present, the sales tax law will be enforced in compliance with the tentative regulations.

tion and advice on this subject. Every physician will benefit by reading this critical analysis of sickness insurance. Moreover, he will be better able after reading it to discuss convincingly the medical profession's viewpoint on such proposals. The article should be preserved for future reference.

During the next few months, Ohio physicians will on many occasions be asked to express their opinion on certain medical and health features of legislative proposals incorporating some of the recommendations of the recent report made by the Commission on County Government.

The highspots of sections of the report dealing with medical and public health subjects are summarized in the article starting on page 138 of this issue of *The Journal.*

Physicians as outstanding citizens and taxpayers should be deeply interested in sound and practicable movements to bring about greater efficiency and economy in government—local, state and national. As members of a profession vitally concerned in medical and public health matters, they should be critical of all suggestions for governmental changes which would affect in any way public health administration or medical practice.

A number of definite recommendations advocating readjustments in Ohio's present system of public health administration have been made by the Commission on County Government. Suggestions have been made for revamping existing local systems of handling welfare and relief activities, including medical care of the poor. In addition, the Commission has advocated sweeping changes in local law enforcement activities, involving the medical aspects of this function of government now handled by the county coroner.

These recommendations should be studied and digested thoroughly by physicians and others interested in the various questions.

This Commission has produced a study of the present plan, or plans, of county government in Ohio, supplemented by numerous suggestions for improvements.

Many of the recommendations may be found practicable and in line with sound public policy. Some of the suggested changes may, after thorough analysis, be found impracticable and undesirable at this time.

It is up to the people of each community to decide what, if any, of the proposals formulated by the Commission should be adopted and put into effect. Naturally, the public will look to groups, including the medical profession, who are best informed on specific phases of the questions at issue, for advice and guidance.

Needless to say, members of the medical profession should be on the job and be fully prepared to give constructive counsel on medical and health aspects of government reorganization questions.

THESE AND SIMILAR ARTICLES SHOULD BE PRESERVED. BE SURE TO KEEP A COMPLETE FILE OF THE *JOURNALS* FOR READY REFERENCE.

—OSMJ—

Plight of the Hospitals

Physicians can sympathize with Ohio's hospitals whose financial plight is acute, largely because of the enormous charity load they have been forced to carry during the past few years.

To be sure, the average physician is but slightly better off than most of the hospitals of the state, in spite of the fact that he is permitted to share meagerly in funds being used for services to those on the relief rolls.

However, it is possible for him to get *some* compensation for his services to the poor under the inadequate fee schedule of the State Relief Commission. Technically, at least, medical service is recognized as a necessity and the furnishing of it a responsibility of government.

With respect to hospitalization, the situation is more acute. Many hospitals are receiving nothing for services to the poor. Unless the community in which the institution is located has funds available and is willing to spend them for hospitalization, the hospital is in most instances out of luck. Under present regulations, state and federal money cannot be allocated for hospitalization.

The hospital's plight is accurately stated in the following comment in a recent issue of *The Modern Hospital:*

"The workings of the minds of governmental bureau heads are often difficult of comprehension. An unfortunate family is allocated three or four dollars a week for the purchase of the bare necessities of life. The physician is permitted to charge a small fee for an office visit and a slightly larger one for treatment in the home. The druggist is paid for medicines.

"But the bronchitis becomes now a pneumonia and the aid of the hospital is necessary. An ambulance is almost immediately at the door, a bed in a well ventilated room, the services of one or more nurses, expensive drugs, six or seven dollars a day for oxygen, all are quickly and uncomplainingly supplied by the hospital. The family dole goes on except that now one less person must be fed, housed and clothed.

"The governmental officials give their acquiescence and approval to all these institutional efforts and expenditures to save life, but that is all. They smugly assert that such is but the hospital's duty. It would be afraid not to continue this fine tradition of gratuitous service. In plain words, the relief bureau is willing to provide the barest necessities to maintain the life of the needy

family, it pays something to the doctor and the druggist. But its financial interest ceases when illness multiplies many times the expense of caring for one of its members. It practically challenges the hospital to make the best of it and to refuse, at its peril, to accept the financial burden thus imposed.

"If hospitals generally would take a firm and concerted stand on this matter, smugness might change to a desire for fair play, and financial justice to the institution would be done."

Obviously, the situation in which hospitals find themselves can't go on indefinitely. Many hospitals are desperately in need of help in carrying their charity cases. They should have it.

Although the medical profession has its hands full trying to solve its own problems, including the poor relief problem, it should not ignore the situation confronting the hospitals and should join with the hospitals in an effort to obtain some relief for those institutions.

Whatever changes may be made in relief programs should not include any move to shift the responsibility for the care of the sick poor from government to the medical profession or to continue to let the hospitals shoulder the burden of hospitalization of those on relief.

— OSMJ —

The Latest Copeland Bill

Commenting on the proposed new Food and Drugs Law, introduced on the second day of the present session of Congress, and comparing some of its provisions with those of a similar measure which failed of enactment in the last Congress, the *United States News* said:

"A stumbling-block in the June bill was the prohibition of advertising cures for a long list of ailments; portions of the public itself were afraid they would not be allowed to buy favorite preparations and take them under the directions on the label.

"The new bill forbids the advertising of cures only for cancer, tuberculosis, venereal diseases, heart and vascular disorders, though by recommendation of the Committee on Public Health (authorized by the act) additions to this list may be made."

If this is a sample of the provisions of the proposed new act, there is grave doubt whether it will have much effect in protecting the public from patent medicine quackery.

Why it would be advisable to forbid the advertising of alleged cures for a few major human ailments and not for numerous minor diseases is, to say the least, confusing and illogical.

No drug or drug preparation should be permitted to carry a label designating it as a cure for any disease—major or minor—unless it has been definitely proven and is generally recognized among the medical profession as such.

Whooping cough may be just as fatal as tuberculosis, or diabetes as deadly as cancer, if the patient neglects to avail himself of competent medical service or relies wholly on some worthless preparation, exploited under a misleading label to give the purchaser a sense of false security in its efficacy.

If the present foods and drugs act is to be amended, nothing should be left undone to put real teeth in it.

In our opinion here is an opportunity for constructive work on the part of those individuals and groups who have been shouting for legislation which will insure the public greater social and economic security, including greater public health protection and a larger share in the benefits of scientific medicine.

If through actual tightening up of the food and drugs laws, many individuals can be prevented from squandering millions of dollars on valueless or detrimental medical preparations, there is reason to believe that a large part of this sizeable fund will be used in the purchase of high-class medical service, which, it is claimed, they are not now able to provide for themselves.

— OSMJ —

The Purchase of Insurance

How much insurance should I carry? What kinds? With what companies?

These are some of the questions the average physician is called upon to answer not infrequently when taking an inventory of his personal affairs.

Those grounded in the fundamentals of insurance have suggested the following three factors as essential in the purchase of insurance of any kind and which should always be kept in mind by the insurance buyer. Obviously, they are somewhat interdependent:

1. A primary consideration is the selection of the agent (counselor, to some). A well-trained, experienced, honest and conscientious insurance representative should be chosen to work out the purchaser's program.

2. Be sure your insurance is placed with reliable and dependable companies, financially and morally. Naturally, if the right kind of agent is selected, there will be little, if any, danger of being swindled through the purchase of cheap but expensive insurance.

3. See that your policies are free from jokers and give you the coverage you desire and are paying for. If the agent and company are dependable they will write only A No. 1 policies.

Physicians as a group are good insurance prospects and good customers of the insurance companies. The nature of their work makes it essential that they have certain insurance protection which the average person does not need or desire.

Unfortunately, many physicians purchase their

insurance in an unsystematic way and without careful investigation of companies, agents or contracts.

As a result, a considerable number of physicians are easy prey for unscrupulous agents working for fly-by-night companies or unreliable companies who solicit business direct by mail or over the radio.

A number of companies of this latter category are at present distributing their propaganda in Ohio. Since the great majority of these firms are not licensed to do business in Ohio, the State Division of Insurance can take no direct action, except to issue warnings.

Insurance companies transacting business in Ohio in compliance with the law, must post a bond of at least $100,000 in cash or securities and submit to rigid examination periodically. Policyholders of such companies are automatically protected from many of the evils arising in the purchase of insurance from non-licensed firms.

Therefore, the physician before he buys any insurance policy should make sure that the company is licensed to write insurance in this state.

— OSMJ —

Business and Social Medicine

Often when the question of socialized medicine is being discussed in mixed circles, the hard-headed business man is heard to remark to his physician acquaintance:

"That's your worry, not mine. It's up to you to solve it."

But is it?

If properly informed regarding the ramifications of socialized medicine, our friend, the business man, will not take such a diffident attitude toward this question, we believe.

For example, it may be difficult for the downtown property owner or office building promoter to realize that he would be directly affected by regimentation of the medical profession. But, as *The Journal of the American Medical Association* has pointed out, by quoting from an article in *Skyscraper Management* by Frank M. Whiston, he is—and vitally.

To quote one paragraph from Mr. Whiston's comments:

"Unless the control of health insurance, state medicine or whatever change in the method of payment is not left in the hands of the organized profession, it will mean the disintegration of medical buildings, so here we are and now let us see what must be done."

Hundreds of similar examples might be offered to prove to the industrialist and man of business, that socialization of medicine is something more than an infant left on the doorstep of the medical profession, for it alone to struggle with.

Menace of Malpractice

Probably one of the most extensive studies of the causes of suits for alleged malpractice against physicians ever made was recently completed by Dr. Halbert G. Stetson and Dr. John E. Moran, both of Greenfield, Mass.

They found that approximately 20,000 malpractice suits have been filed against physicians in the United States during the past five years.

Data on 35,000 suits, furnished by various liability companies and physicians, was analyzed by Dr. Stetson and Dr. Moran and their findings published in *The New England Journal of Medicine*, Vol. 210, No. 26.

The causes of these 35,000 suits, as determined by their analysis, were, in the order of importance:

Inopportune remarks by subsequent attending physicians.

Personal enmity and jealousy between members of the profession.

Counter suits interposed as a defense against the suit brought by a doctor for the purpose of collecting his fee.

Failure to use the *X*-ray in the diagnosis and reduction of fractures.

Outside causes, such as newspaper articles, cults, etc.

Negligence of the nurse employed by the physician.

Alcoholism (rarely).

Failure to use a method of treatment which is used by the majority or a respectable minority (rarely).

Members of the medical profession can find no comfort but rather chagrin at the finding of Dr. Stetson and Dr. Moran that 60 per cent of the 35,000 cases studied were the result of inopportune remarks by physicians, because of lack of knowledge concerning the facts or because of personal animosity or jealousy, in comparison to 20 per cent as a result of counter suits; 10 per cent due to failure to use the *X*-ray and 10 per cent from all other causes.

Quite properly, the report emphasized that prevention of suits is the profession's chief defense against this menace. It is pointed out that the physician who imagines he is being relieved of financial obligation because he carries liability insurance is only partially correct since insurance rates are in direct ratio to funds paid out by the insurance companies and are assessed alike against the guilty and the innocent.

The investigation by Stetson and Moran shows why preventive activities such as those carried on under the Medical Defense Plan of the Ohio State Medical Association are so essential and necessary even if every physician carried all the liability insurance it were possible for him to obtain.

THE CLINICAL SIGNIFICANCE OF ACHLORHYDRIA

By C. D. CHRISTIE, M.D.,

Cleveland, Ohio

ABSENCE or extreme diminution of hydrochloric acid in the stomach in a variety of clinical conditions has been a frequently emphasized clinical finding; in fact, it has been one of the trite and hackneyed subjects of medicine during the past fifty years. Detailed case descriptions of its recognition alone and in association with a variety of clinical conditions has been amply emphasized. The clinical significance of the finding has been freely speculated upon in this profuse literature, but since the clinical recognition of many deficiency states is of comparatively recent date, it has seemed worth while to review the one in the light of the other.

Achlorhydria has been so frequently observed in seemingly normal, as well as abnormal people, and physicians have so religiously advised the use of hydrochloric acid by such individuals, yet so infrequently have they noted any demonstrable changes that a school of thought has grown up which inclines to attach little or no significance to the finding. Occasional instances where the administration of hydrochloric acid has seemed beneficial in aiding the symptoms of which certain patients complain, physicians have often been so skeptical that they have attributed the results to psychic influences. The cause for much of this confusion on the subject, as will be pointed out later, was due in many instances to error in diagnosis. Therefore it is not with the idea of going over again this old subject, and of attempting to enumerate all of the things that hydrochloric acid by mouth may be good for, but instead to emphasize a conception of the significance of its absence from the stomach in the light of our modern knowledge of nutrition, which may be of greater clinical value than we have been able to attach to it heretofore.

For a time following the memorable pathological observations by Fenwick in 1880, recorded in his book on "Atrophy of the Stomach", there was an increasing attempt on the part of the profession to make a clinical entity of the finding of absent hydrochloric acid in the stomach. These attempts fell into disrepute because physicians found with their pernicous anemia patients and the carcinomas of the stomach, where the acid was known definitely to be absent, that neither were cured or appreciably improved after its liberal administration.

Slowly it was recognized that the achlorhydria was merely an incident in a variety of clinical conditions, more constant to some, and less to others. Sometimes it was noted in apparently healthy people, and since the administration of the acid by mouth had so often been disappointing, the tendency was to ignore the finding. We mostly find ourselves in this latter stage at the present time. As proof of this statement, if one refers to the extensive literature which has grown up in the past ten years on pernicious anemia and other deficiency states, it will be found that slight attention has been given to achlorhydria in most of the reckoning on these conditions. Many argue that the condition is mostly symptomless and therefore requires no attention. This line of reasoning is false. Many patients with achlorhydria do have definite symptoms, and all are potentially vulnerable for more serious ones later.

It seems to matter little whether the patient is afflicted with some clinical condition with which the lack of acid in the stomach is commonly associated, or whether this finding would seem to be about the only objective one. The symptoms from achlorhydria may be varied, not always constant in degree, and certainly at times so mild that they scarcely excite curiosity on the part of the patient. It is the very mildness of the symptoms, and the fact that the patient manifests little or no curiosity about them, which offers the justification for coming before you with this discussion. By its neglect it may be that the ground work is being laid for what may prove to be trouble in later years.

The criteria for the establishment of the absence of hydrochloric acid from the stomach are not always easy. Doubtlessly in the past, physicians have been led into error many times on the diagnosis of achlorhydria, and people given the acid when they had an adequate supply. The custom of using the old test meal was mainly the reason for the error. The test meal often was a strongly buffered alkaline solution, and led to neutralization of the acid. For this reason the older data on the subject is not so reliable. If there has been much "gagging" on the passage of the tube, alkalinization may take place from excessive mucus secretion, or from regurgitation of bile into the stomach. Obviously in either event it would be easy to fall into error. However, if 50 cc. of 7½ per cent alcohol be administered to the patient after the fasting specimen has been obtained, and no hydrochloric acid demonstrated in 45 minutes after, it is good presumptive evidence

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that none exists, providing there has not been excessive "gagging". By using alcohol we have a substance for a test meal which is safe because it has no alkaline buffers. If there is doubt, the test should be repeated, and perhaps the specimens taken, not alone after alcohol administration, but after the hypodermic injection of .5 mg. of histamine. It is doubtful whether this last procedure is scarcely ever necessary. Certainly if there is complete absence to ordinary tests after two administrations of 7½ per cent alcohol, the inference is allowable that no hydrochloric acid exists.

If achlorhydria means anything more than a coincident in certain individuals' lives, then the recognition of those with mild symptoms is as important as the more severe ones. Failing appetite, and especially a gradual dislike for meats, should immediately excite suspicion. This has been one symptom which has impressed me more than any other. In several instances of individuals who have come to my attention with pernicious anemia of relatively recent origin, they had completely, or essentially completely, given up the use of meats in their diet years before, and in one instance as much as 25 years before. There are now many instances in the literature of patients definitely known to have had achlorhydria for as much as ten years before their pernicious anemia appeared.

Because of the failing appetite, weight loss may be gradual or marked, depending upon the severity. Sore tongue may be present, and very commonly loose bowel movements, often fatty to a greater or lesser degree, with much flatulence at times, and disturbed sleep. With the failure of nutrition from the impaired appetite, sore tongue, loose bowel movements, etc., progressively increasing weakness supervenes, giving rise to a more or less definite clinical picture. If all of the patients with absence of hydrochloric acid presented such a definite picture there would be little excuse for overlooking any of them, but such is not the case. However, there are many who are consistently overlooked who do present all or many of these symptoms. As a striking example, one case will be briefly reported.

In 1919, a Bohemian man, age 58, consulted the late Dr. C. F. Hoover at Lakeside Hospital in Cleveland, because his family physician had found sugar in his urine, and because he had completely lost his appetite, ate only with the greatest difficulty, and his weight had decreased from 200 lbs. down to 180 lbs. Dr. Hoover found that the man was not a diabetic, but he had a complete achlorhydria. There were no other positive findings. He recommended to his physician that the patient be given hydrochloric acid. The patient's physician did not see fit to follow this advice, since the positive sugar reduction in the urine which he got impressed him as a more reasonable explanation of this patient's disability than the achlorhydria. He was sent to another hospital in this city so that the supposed diabetes mellitus could again be investigated. Again the advice was that there was not sufficient diabetes mellitus to account for the symptoms, but no explanation was given at this time for the impaired appetite and weight loss. Dr. Hoover's findings were lost sight of completely.

The individual being a man of considerable means decided to take the situation in his own hand. He set off about the country visiting various clinics. He would go in and present the question—"Am I a diabetic?" After more or less thorough study he would be told that he was not a diabetic, but no explanation would be given for his poor appetite, weight loss, and loose bowels. He repeated this performance in at least three clinics in Europe. In 1927 he came under my observation. He presented the same question to me—"Am I a diabetic?" It was readily apparent that he was not a diabetic, but from his story it was felt that he likely had an absence of hydrochloric acid. This was proved and the old record of Dr. Hoover's earlier experience with him uncovered. There was little or no change in his clinical condition over what it was when seen by Dr. Hoover, except his weight was now 160 lbs. He was tired, irritable, and food was repulsive to him. He was immediately put on an adequate hydrochloric acid dosage before and during meals. His appetite promptly came back. He gained weight up to 185 lbs. His loose bowels subsided and his feeling of well being returned. He remained faithful to hydrochloric acid until his death in 1933 from coronary thrombosis. During the six years which he lived after the institution of hydrochloric acid he had next to no complaints.

Other instances almost as striking as this one could be presented, but this will suffice to emphasize the point which I wish to make, and that is, that the absence of hydrochloric acid from the stomach often leads to more or less unimpressive symptoms, as failing appetite, etc., extending over long periods of time, and with the administration of the acid the clinical condition often is unmistakably improved. In the light of our present nutritional knowledge, here was an individual who was constantly undergoing mild starvation from essential food stuffs, as well as perhaps essential vitamins and minerals, over a long period of time. It is doubtful whether any would contend that such a clinical situation would not sooner or later lead to disaster.

It is a well known clinical fact that the absence of hydrochloric acid from the stomach is a more or less constant finding in most known deficiency states, as pernicious anemia (or macrocytic anemia) and achlorhydric anemia (or microcytic anemia—iron deficiency), in beri beri (vitamin B deficiency), pellagra (vitamin B-2 or skin fraction deficiency), and scurvy (vitamin C deficiency). The same holds true in a host of other conditions where deficiency states are believed to exist, but in which the actual cause of the deficiency is not known. Achlorhydria is a frequent finding in sprue, idiopathic steatorrhea or celiac disease, Plummers-Vinson syndrome, the neuritis of chronic alcoholism, uncertain skin manifesta-

tions, vague disturbances in water balance, and finally in chronic atrophic arthritis.

If one observes many of these deficiency states, the impression will ordinarily be gained of the great similarity between many of the symptoms which they present, and those in which the only known deficiency is that of hydrochloric acid, as the smooth, red, sore tongue, failure of appetite, flatulence, loose bowel movements, weight loss, etc., with a progressive failure of nutrition. From this point on, many of these known deficiency states, or supposed deficiency states, take on individual characteristics which lead to a more or less definite clinical picture to which a name can be attached. To many of them there is an obvious profound disturbance in nutrition with a great confusion of symptoms and signs representing perhaps several greater or lesser deficiency states to which no name can be attached. However, it is imperative to emphasize again that with all of this mass of confusion of signs and symptoms in both that group to which we can attach a name, and to those profound nutritional disturbances in which it is felt that one or more deficiency states exist, to which a name cannot be attached, that perhaps the absence of hydrochloric acid from the stomach is the finding most common to all of them.

It is not my desire or intention to try to convince you that absence of hydrochloric acid from the stomach is the fore-runner or cause as it were of all deficiency states, for most every physician doubtlessly knows of an occasional patient who has shown this condition over a period of years with no apparent ill effect, and at the same time has known of patients with marked deficiency states with adequate hydrochloric acid in their stomach. It goes scarcely without saying that individuals may not get their proper share of vitamins or minerals from a variety of causes. Economic reasons may be the cause, or an occasional individual may become convinced that after all food is useless and that alcohol is the only thing worth while. Some have been known who have followed this theory until their vitamin and mineral stores were completely replaced by alcohol and the remnants of the copper still from which it originated. Finally, a great host of these deficiency states are undoubtedly dependent on more serious pathological states, as malignant and obstructive disease in the gastrointestinal tract, which not only interferes with the normal progression of food through the digestive tube, but also interferes with the absorption of its essential elements. The same would hold for ulcerative diseases of the gastrointestinal tract which would lead to rapid progression of food over the absorbing surfaces. A great host of other conditions might be enumerated which would be conducive to deficiency states, but again achlorhydria is common to most of them.

The evidence that achlorhydria does interfere with absorption from the stomach can be briefly reviewed:

(1) In the treatment of patients with iron deficiency anemias in which there is a definite achlorhydria, the rapidity with which iron is absorbed is markedly interfered with, as indicated by the slowness in the improvement of the anemia. If hydrochloric acid be given simultaneously with the iron in such clinical conditions, the improvement is much more prompt. This point has been frequently emphasized in the recent literature on achlorhydria anemia.

(2) Again the work of Castle* seems to emphasize further that acid in the stomach is a necessary factor for proper absorption and utilization by the body of certain essentials from the food. His simple yet ingenious experiment established this point beyond question. He administered beef steak daily to patients with primary anemia. No improvement occurred either clinically or in the blood. However, by feeding beef steak to normal individuals, and then recovering it after one hour of digestion has taken place, and refeeding it to these same patients with pernicious anemia, there was prompt amelioration of symptoms and improvement in the blood. This proved that normal gastric juice did something to the beef steak that made it readily utilizable. Inasmuch as hydrochloric acid is a known substance to be absent from the stomach of the patient with pernicious anemia, it is good presumptive evidence that it may play a part.

(3) Finally, this point is more firmly established when it is viewed in the light of the marked amelioration of digestive symptoms and clinical improvement which we often see in patients with absence of hydrochloric acid when nothing else is done but the daily administration of the substance by mouth, as was accomplished in the patient that has just been described to you.

The mechanism by which the absence of hydrochloric acid in the stomach produces marked symptoms in some and few or none in others is little understood. Unquestionably, the length of time that an achlorhydria must exist before symptoms are produced is also a great variable. Why some get a particular vitamin deficiency in its presence, yet others a particular mineral deficiency is still less understood, but one thing seems clear from the gradual accumulating evidence, and that is that the achlorhydria is in all probability a potent factor. Whether the presence of the acid does something to the chemistry of vitamins and minerals to make their absorption and storage possible, or whether it contributes to certain alterations in the absorbing membranes of the gastrointestinal tube are little understood questions.

It is my feeling, both from experience and a

* Castle, W. B. Observations on the Etiological Relationship of Achylia Gastrica to Pernicious Anemia. Am. Jour. Med. Sc. Vol. 178. P. 748. (1929).

gradual accumulating evidence in the literature, that achlorhydria is of distinct clinical significance to the patient and perhaps may be as important to his future well being as the recognition of myxedema. Such individuals, if they do not have at the moment deficiency states, should be considered as potential possibilities for these conditions, and studied with this point of view in mind. If they prove to have no evidence of deficiency states they should be observed from time to time and not wholly neglected. Individual instances will have to be considered on their own merit, but there is little objection to asking an individual to take dilute hydrochloric acid by mouth. At the same time it is a simple matter to go over one's eating habits to make sure that the kind and quality of their daily food intake is sufficiently well balanced to provide an adequate supply of all known essential vitamins and mineral factors. If there is a question of inadequacy in any of them, again it is a simple matter to add some one or all of the known concentrates to any individual's daily diet.

To summarize, it is my feeling that simple achlorhydria may not of itself cause symptoms, but if long neglected may apparently cause symptoms itself or be the forerunner, or prepare the field as it were, for later profound nutritional changes. That from its long existence, deficiencies of vitamins or minerals may take place and lead to the clinical picture characteristic of the one or the other, depending upon the missing factor or factors. After all, we must keep the fact in mind that the state of one's nutrition bears a constant relationship to the kind, quality and amount of the nourishment absorbed by the digestive tract.

10515 CARNEGIE AVENUE.

THE REPRESENTATION OF VISCERAL FUNCTION IN THE BRAIN

By A. R. VONDERAHE, M.D.,*

CINCINNATI, OHIO

THE careful analysis of the peripheral autonomic nervous system by anatomical, physiologic and pharmacologic methods, leads to a division into two distinct systems with antagonistic functions: the cranio-sacral autonomic or parasympathetic system and the thoracolumbar autonomic or sympathetic system proper. The analysis has even been carried into clinical terminology by reference to vagatonia and to sympathicotonia as clinical entities. In the healthy person, however, it is obvious that a fine state of balance is maintained between these opposing functions and in the disturbed person it is not uncommon to see mixtures of parasympathetic manifestations with sympathetic manifestations.

This data can only be explained by assuming some higher center in the nervous system where both divisions are represented and controlled. Again, one can deduce the presence of such a higher center from the nature of emotional states, where mixtures of parasympathetic and sympathetic signs are constantly occurring in patterns so obvious that children and even animals appreciate them. In the emotion of joy, there is a diffuse dilatation of the peripheral vessels, a parasympathetic function, with a rapid heart beat, a sympathetic function. In the emotion of shame or embarrassment, there is a mottled dilatation of the vessels of the face and upper thorax, a parasympathetic function, with a rapid heart beat, a sympathetic function. These constant patterns of emotional expressions with distinctive and specific reactions now primarily parasympathetic, now primarily sympathetic, now a mixture of both, but in each instance with a conscious feeling, precise and unmistakable, serve to indicate the presence of a central substratum for the two opposing functional systems. Fortunately, enough observations are now at hand to enable us to lay aside deductive inquiry for the more specific information afforded by observation and experiment.

HISTORICAL

"Like the nugget in the innermost series of Chinese boxes," as Cushing's phrase goes, lies the doubly protected, well hidden and centrally placed pituitary body. The early anatomists were amazed at its structure and that of the immediately overlying region of the brain. Galen called the region above it the *plexus retiformis* and to record his amazement at it those who followed much later called it the *rete mirabile.* In the seventeenth century Willis identified the vascular characteristics and the circle of blood vessels is still identified by his name. Galen thought that vital spirits were transformed into animal spirits in the ventricles of the brain and that the waste products were filtered through the pituitary into the nose, whence the name pituita or slime. Willis found this hypothesis untenable as Schneider some time before had demonstrated

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From the Department of Anatomy (Neurology) University of Cincinnati, Medical School.

that pituita or slime was secreted by the nasal mucous membrane itself. In ascidian larvae, the mouth and brain are in communication, and in the embyronic life of all vertebrates a demonstrable duct exists at some stage of development. The curious doctrine of "vestigial structures" i.e., that certain structures in higher animals are mere vestiges of structures of functional importance in lower animals but no longer important in the higher form, apparently impeded further study. In 1778, the pituitary body was renamed the hypophysis and then forgotten.[1]

Marie[2] in 1886 described the remarkable alteration of mineral metabolism, acromegaly, and in 1901 Frölich[3] described the disease, *dystrophia adiposogenitalis* and pointed out that a tumor of the pituitary body may occur without acromegalic changes. In 1892 Dercum[4] described the syndrome of *adiposis dolorosa* and in 1900 Burr[5] found a pituitary tumor in a typical example of the disease while Cushing[6] in 1912 described cases which at autopsy showed no obvious hypophyseal lesion.

There is an obvious caution in Cushing's writings even at this early period with respect to ascribing too many functions to the pituitary. Subsequent studies revealed the correctness of his attitude, for, in 1921 Bailey and Bremer[7] described the results of systematic punctures of the hypothalamus in dogs, in each instance the pituitary body being kept intact; the syndrome of diabetes insipidus, polyuria and polydipsia followed in every one of the dogs so treated and, in addition, in some of the dogs cachexia, genital atrophy, adiposogenital dystrophy, convulsions or inconstant glycosuria occurred. They questioned the widely acepted views of the time that adiposogenital dystrophy is due to a deficiency in the secretion of the anterior lobe of the pituitary and pointed out vigorously the role which the hypothalamus plays in the production of these metabolic disturbances. The reasonableness of this view becomes obvious when we consider that the pituitary body is quite confined in its bony sella turcica and any neoplasm occurring in it has a tendency to thrust upward making pressure on the optic chiasm and the adjacent ventral portions of the hypothalamus. In addition the intimate vascular relationship of the pituitary body with the hypothalamus permits us to understand why extremely small pituitary lesions may be productive of pronounced metabolic disturbances. The separation of functions traceable to the pituitary body itself and those traceable to the overlying hypothalamic area of the brain has proceeded steadily. The recognition of the important role which the hypothalamus plays in the production of visceral and metabolic syndromes by Cushing[8] is a matter worthy of special note.

The role of the hypothalamus as a vegetative center was anticipated by the pioneer work of Malone[9, 10] on the cell groups of the diencephalon. In an exhaustive analysis of this region Malone classified the nuclear groups on the basis of cytologic characteristics and by the same criteria identified this area as visceral in its function. Subsequent experimental studies have abundantly verified the correctness of his view. Comparative anatomical studies by Papez and others[11, 12] have demonstrated the phylogenetic antiquity of the hypothalamus, its consequent importance, and by classifying analogous nuclear groups on the basis of topographical relations, condensations, and fiber connections, have supplemented the nuclear classifications of Malone made on the basis of cell type and cytologic characteristics, so that a complete morphologic ground-work now exists for further physiologic and pathologic studies. Accordingly, there can now be accurately described the effect of specific toxic factors reacting selectively on neurones according to their cytologic character by using the classification of Malone; and, the effect of localized lesions in neurone groups by using the classification developed primarily by the comparative anatomists.

MORPHOLOGY OF THE HYPOTHALAMUS

The anatomic division of the nervous system which forms the basis of inquiry as to its relationship to visceral function may be designated in general terms as the *hypothalamus*. It may be divided into three parts:—(1) the *pars optica hypothalami* consisting of the *optic chiasm* and the *lamina terminalis*, (2) the *subthalamus* consisting of the *corpus subthalamicum* or *Body of Luys*, and (3) the *pars mammillaris hypothalami* consisting of the *mammillary bodies*, *tuber cinereum*, *infundibulum*, and *neurohypophysis* or *posterior lobe of the pituitary body*. The structures assigned to the *pars mammillaris* are those primarily concerned here.

The hypothalamus lies ventral to the dorsal thalamus and dorsal to the sella turcica with its pituitary body. Anteriorly, its lamina terminalis marks the end of the primitive neural tube and separates it from the medial longitudinal fissure. Posteriorly it becomes continuous with the structures of the mid-brain. The structures which comprise it surround the cavity of the third ventricle.

The nuclear groups of the tuber cinereum are especially pertinent to the present discussion. They have been classified by Malone[9, 10] as follows: (1) *nucleus tubero-mammilaris*, (designated by other authors n. hypothalamicus lateralis, n. perifornicalis, or n. mamillo-infundibularis); (2) *nucleus paraventricularis hypothalami*, (other authors have designated it n. hypothalamicus magnocellularis, n. preopticus pars magnocellularis, or n. filiformis); (3) *nucleus supraopticus*, (early writers called it the basal optic ganglion); (4) *nucleus tuberis lateralis*, (this nuclear group is sometimes called simply nucleus tuberis); (5) *substantia reticularis hypothalami;* (6) *substantia*

griesea of the third ventricle, pars superior and *pars inferior.*

In the substantia grisea, condensation of cells occur, which in lower animals especially, are consistently present and recognizable. Accordingly, many authors have divided this cellular region into the following: (a) nucleus hypothalamicus anterior, (b) nucleus hypothalamicus parvicellularis, or, according to some writers, nucleus filiformis, (c) nucleus ovoidus, (d) nucleus hypothalamicus ventromedialis, (e) nucleus hypothalamicus dorsomedialis, (f) nucleus periventricularis posterior, (g) nucleus periventricularis anterior, (h) nucleus periventricularis, (i) nucleus hypothalamicus posterior.

The fiber connections of the hypothalamus require further investigation. Many of the fiber pathways are finely medullated or non-medullated so that the study of their connections is difficult. The following summary must be understood, therefore, with some reservations and considered more in the nature of a working hypothesis than as finally demonstrated, although evidence exists for its support. The afferent connections of the hypothalamus may be grouped as follows:—

(1) Olfactory impulses from the olfactory area transmitted over the *medial forebrain bundle* to the nucleus tubero-mamillaris,

(2) Auditory and vestibular impulses transmitted over the *ventral supra optic decussation, pars dorsalis,* or *Gudden's commissure* to the nucleus hypothalamicus anterior,

(3) Visual impulses from optic centers, especially the pars ventralis of the lateral geniculate body, over the *ventral supra-optic decussation pars dorsalis* or *Meynert's commissure* to the nucleus hypothalamicus anterior,

(4) Striatal influences from the nucleus of the dorsal supra-optic decussation over the *dorsal supraoptic decussation,* or *Ganser's decussation* to cells of the anterior and ventral part of the substantia grisea of the third ventricle,

(5) Olfactory impulses from the amygdala over the *stria terminalis* to the anterior portion of substantia grisea,

(6) Olfactory impulses probably related to bladder, rectal and sexual function from the gyrus subcallosus over the *septo-hypothalamic tract* to end in the substantia grisea in the preoptic area,

(7) Higher conscious impulses from the premotor area, over the *cortico-hypothalamic fibers* to the nucleus dorso-medialis hypothalamicus and probably to the paraventricular nucleus.

The efferent pathways may be tentatively considered as follows:—

(1) A sympathetic pathway from nucleus hypothalamicus posterior, over the periventricular fibers to lower autonomic centers in the brain stem and spinal cord,

(2) A parasympathetic pathway from the nucleus paraventricularis and nucleus tuberis mammillaris to the vagal autonomic centers in the medulla,

(3) A pathway from the paraventricular nucleus and the supra-optic nucleus via the infundibulum to the posterior lobe of the pituitary body.

One of the most striking discoveries in recent years is the demonstration of a portal circulation between the pituitary body and the tuber cinereum[13, 14]. The pituitary body and the adjacent portion of the hypothalamus receive a systemic blood supply from small arterial branches from the circle of Willis. In the pituitary body sinusoids are formed from whence minute portal veins carry blood to the hypothalamus; the hypothalamus receives accordingly systemic arterial blood as well as blood drained from the pituitary blood sinuses among the glandular cells. A well marked capillary plexus is formed by portal vessels in the paraventricular nucleus. The portal vessels are distinguished from the systemic vessels by the absence of a Virchow-Robin space.

PHYSIOLOGY

Reference has been made to the experimental production of diabetes insipidus and adiposogenital dystrophy by puncture of the tuber cinereum in dogs, by Bailey and Bremer.[7] Camus and Gournay[15] produced glycosuria in rabbits by destruction of the paraventricular nucleus. Body temperature regulation is intimately associated with this area according to Morgan[16].

It appears obvious that there are located in the hypothalamus, areas intimately associated with the regulation of fat, protein, carbohydrate, mineral and water metabolism, temperature regulation, regulation of internal and external glandular secretion, vaso-motor mechanisms, and sleep. It seems reasonable, too, that in this regulatory process the well demonstrated mechanisms of the sympathetic and of the parasympathetic autonomic nervous system would be utilized. That this is very likely the case is shown by recent work, which suggests that the anterior portion of the hypothalamus is related to parasympathetic function and the posterior portion to sympathetic function. As pointed out earlier in this paper it is also necessary to account for the physical manifestation of specific emotions and for certain clinical pictures which present mixtures of sympathetic and parasympathetic effects. The analysis, true though it may be in general, is perhaps not as uncomplicated as appears at first sight.

Cannon[17] studied bodily changes resulting from states of mental excitement, fear and rage, and pointed out that in these emotions there is an increased production of adrenin followed by vasoconstriction in the abdominal viscera, rise in blood pressure, rise in blood sugar, diminution of coagulation time, etc. Bard[18] sectioned the nervous system at various levels and found that the rage reaction continued to occur until a small triangular segment just posterior to the stalk of the pituitary was excluded. When this small segment was removed, the rage reaction no longer occurred. It is thus suggested that a portion of the hypothalamus caudal to the infundibulum is sympathetic in its influence.

Levy[19] noted that chloroform anesthesia produced a cardiac arrhythmia, characterized by

many ventricular extra-systoles. The phenomenon did not occur when the stellate sympathetic ganglion was removed. Beattie, Brow and Long[20] confirmed the observations of Levy and found that if the animal was decerebrated at the collicular level, thus excluding the hypothalamus, the extra-systoles did not occur; while if the decerebration was carried out in a plane which did not remove the posterior hypothalamic nuclei, the extra-systoles remained.

Still further evidence was produced by Beattie, Duel and Ballance[21] who utilized the earlier observations of Karplus and Kreidl[22] that stimulation of the posterior hypothalamus produced a rise in blood pressure, although the adrenals were removed, and dilatation of the pupils, and of Beattie that stimulation of a small area on the lateral and posterior wall of the third ventricle would produce dilatation of the pupil on the same side. They joined the central cut end of the sympathetic trunk with various peripheral motor nerves to muscles of the tongue and neck. After a period of from five to six months, to permit regeneration, stimulation of the posterior hypothalamic nuclei gave responses in muscles into which the sympathetic trunk had regenerated. Clear as this experimental evidence is, the anatomic pathway is not demonstrated with certainty.

While the sympathetic function is characterized by a massive discharge of energy, parasympathetic function is frequently individualized through its component nerves as well as generalized. The increased complexity of function manifested by the parasympathetic, suggests an increased morphologic complexity. This added complexity is found in the nuclei and connections of the anterior portion of the hypothalamus.

Cushing[33] observed the effects of pituitrin injected directly into the lateral ventricle in human subjects and found these effects to be directly opposite to those of pituitrin injected intravenously, e.g., on ventricular injection there was vasodilation, fall in the blood pressure, profuse perspiration, and marked lowering of body temperature. Recalling the portal circulation previously described between the pituitary body and the tuber nuclei, it appears very probable that the internal secretions of the pituitary can effect directly nerve cells in this region. While the nervous pathway has not been adequately demonstrated it is possible that the fibers streaming from the dorsal and posterior portion of the paraventricular nucleus may be the means of transmitting impulses to the lower centers of the parasympathetic nervous system.

CLINICAL OBSERVATIONS

An attempt will be made to apply this recent knowledge by dividing clinical cases into: (1) syndromes primarily related to the posterior hypothalamus, case 1, (2) syndromes primarily related to the anterior hypothalamus, cases 2 and 3, and (3) syndromes related to both anterior and posterior hypothalamus, cases 4 and 5. It seems most probable that the majority of clinical cases represent an involvement of both the anterior and posterior hypothalamus.

Case 1. Eppilepsy, attacks of rage, and "dyspituitarism."—The patient, a girl of 15 years, complained of several attacks of unconsciousness with the onset only a few days before the consultation. There were no convulsive disorders at any time in infancy or childhood. An operation for chronic appendicitis was done but had no apparent relation to the progression of her illness. During the course of the year the convulsions, of a typical epileptiform character, increased in number. Attacks of petit mal occurred several times daily. Menstruation had always been irregular, intervals of five weeks to three months elapsing between periods. More recently, attacks of boring headaches in both temporal areas began to occur and became more persistent in character.

Examination revealed a tall, thin girl with an increased growth of hair on arms and legs. The cranial nerves presented no abnormalities. The remainder of the neurological examination presented nothing abnormal aside from moderately hyperactive reflexes. Examination of the eye grounds showed nothing abnormal. Perimetric examination showed some diminution of the field of vision on the temporal side. The blood Wassermann was negative. *X*-rays of the head revealed nothing abnormal.

As the illness progressed there developed, in addition to the continued convulsive attacks, attacks of unreasonable anger of such severity at times as to be completely uncontrollable by her family.

Comment: This case presents sufficient evidence to be classified as a pituitary tumor suspect. The attacks of rage occurring in this case are regarded as explainable on the basis of an irritation of the posterior portion of the hypothalamus.

Case 2. Adiposis Dolorosa, "poly-glandular syndrome." The patient, a woman of 47, entered St. Mary's Hospital complaining of general weakness and generalized pain, both of which difficulties had increased in severity during the past year. The patient also complained of increased thirst and increased urination. The patient had always been overweight. Menstruation began at 14 but stopped completely at 18 and did not return thereafter.

The examination revealed a woman weighing 285 pounds confined to her bed in a state of obvious distress. The adipose tissue was fairly evenly distributed but more prominent about the trunk. There was a brownish pigmentation in the skin. Repeated basal metabolic tests gave readings of -12 to -20. Sugar was present consistently in the urine. There was increased intake and output of fluids. The blood Wassermann was negative. The neurological examination revealed no local neurological signs. Eye grounds were clear. *X*-ray of the head revealed nothing abnormal.

Comment:—This case was classified as Dercum's Disease. It is obvious that there was a derangement of many internal secreting glands: diabetes (pancreas), low basal metabolic rate (thyroid), pigmentation (adrenals), cessation of

menstruation at an early age (ovaries), increased fat deposits (pituitary).

While it is possible to explain a case of this sort on the basis of a separate pathologic involvement of the individual internal secreting glands, it is more probable that one central lesion is responsible for the syndrome. In this case it is therefore likely that an involvement of the hypothalamus occurred wherein the central representation of the innervation of the internal secreting glands was disturbed.

Case 3. Diabetes Mellitus, hemorrhage of the mid-brain.—The patient, aged 67, for several years attended the clinic at the Cincinnati General Hospital for hypertension. Repeated urine examinations showed no evidence of sugar at any time. After a "stroke of paralysis" the patient was brought to the Cincinnati General Hospital in a comatose state, presenting at this time a right sided hemiplegia. The urinalysis now showed 4+ sugar. The patient died four days later. At autopsy there was found a hemorrhage, having its origin in the left half of the mid-brain and thrusting portions of the midbrain upward so as to compress the cavity of the third ventricle.

Comment:—The origin of the glycosuria in this case is regarded as due to compression of carbohydrate metabolic centers in the hypothalamus, or to destruction of the pathways from this area in the reticular formation of the midbrain.

Case 4. Diabetes Insipidus, narcolepsy, vegetative changes.—The patient, aged 40, of mixed colored and white blood, complained of headaches and visual disturbances increasing in severity during the previous year. Frequent and profuse urination developed. At times he would fall asleep during the day, on one occasion, while leaning against a pole. There was a gradual increase of pigmentation of the skin. Diminution of memory and sexual impotence occurred, and the hair rapidly turned gray and then fell out.

The physical examination confirmed the above subjective complaints. There was bilateral choked discs. Reflexes and sensation were within normal limits; there was, however, some incoordination in the arms and a positive Romberg sign was present.

A tumor, which was not removed at operation, was found on post-mortem examination. The tumor was an ependymoma filling the entire cavity of the third ventricle and obstructing the aqueduct of Sylvius producing an associated internal hydrocephalus.

Comment:—This case presents a clinical picture of diabetes insipidus, narcolepsy, pigment change in skin, changes in hair follicles, and impotence, associated with pressure destruction of large portions of the floor and walls of the third ventricle.[24]

Case 5. Epilepsy, status epilepticus followed by unilateral edema.

The patient, a white woman of 48, suffered from attacks of epilepsy since early childhood. The convulsions were typical and occurred at varying intervals of one to three weeks. For many years no treatment whatsoever was followed. A period supravened in which the convulsions occurred with greater frequency and status epilepticus developed. This state was fairly well controlled by injection of Luminal intramuscularly. The convulsions ceased and the patient remained in a confused state for six weeks after which there was a gradual clearing of consciousness. At this time it was noted that the right arm and leg were enlarged markedly and that the skin pitted on pressure. The urinalysis at no time showed any abnormality. Over a period of three months the unilateral edema persisted but finally receded.

Comment:—In this case there is to be noted a unilateral disturbance of water metabolism. Taking into consideration the work of Morgan and coworkers[25] there appears to be a suitable explanation for this finding, in the disturbance of water regulatory centers located in the anterior portion of the hypothalamus.

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DISCUSSION

T. A. RATLIFF, M.D., Cincinnati: The paper presented here indicates very clearly the growing relationship between neurology and internal medicine. It is apparent that all problems of metabolism need to be re-examined in terms of neurologic mechanisms. The actions of various drugs on the central nervous system, too, may be more accurately studied as our knowledge of visceral representation in the central nervous system grows.

The relationship of the hypothalamus to the physical expression of emotions, indicated here, is a matter of striking interest to the psychiatrist. Psychoanalytic studies, although emphasizing a purely psychologic approach, take into consideration in their entirety physical disturbances involving all parts of the organism. We have here explained the physical substratum for production of physical symptoms so common in psychoneuroses as well as in the psychoses. The physical manifestations of conflict, associated as they are with conscious and unconscious levels, and with memory images reaching back to intrauterine existence, are inseparably linked with the hypothalamus. Through the interconnection of cortical and perhaps thalamic pathways acting upon the hypothalmic centers the emotional conflict reaches external expression in physical symptoms, while the totality of the process is no doubt the basis of the conscious perception of an abnormal emotional state such as elation, depression, anxiety and apathy.

MUCUS MEMBRANE COLOR CHANGES AS AN INDEX TO TREATMENT IN CHILDREN

By STANLEY D. GIFFEN, M.D.,

TOLEDO, OHIO

INTRODUCTION

TWENTY years ago Dr. J. A. Stucky of Lexington Ky., and Dr. D. O. Jarvis of Barre, Vt., independently noted a clinical relationship between the food selection of the individual and the clinical condition he presented. Their mutual interest later grew to a point where a correspondence, discussing the relationship of biochemistry to clinical conditions, was carried on. This correspondence has grown to a group of fifty clinicians who continue to discuss, by an exchange of letters, the relationship of bio-chemistry to clinical conditions of the body.

CLINICAL OBSERVATIONS MADE BY DR. JARVIS

While examining the upper respiratory tract and inquiring into the food selection of 500 granite cutters for the National Tuberculosis Association, Dr. Jarvis noted that a relationship existed between the food selection of the granite cutter and the appearance of his nose and throat. Later he examined several groups of individuals in private schools, the Vermont Hospital for the Insane, and the Washington County Tuberculosis Hospital. From an examination of these groups and patients seen in hospital and office practice the following conclusions were reached: (1) Lymphoid tissue is present in the upper respiratory tract in proportion as fats are absent from the diet. (2) An increased redness of mucous membrane is present when the individual selects most of his food from acid ash producing foods. (3) A pale mucous membrane is present when the individual selects most of his foods from alkaline ash producing foods. (4) A watery or muco-purulent nasal discharge is present when the individual crosses his line of tolerance for sweets.

CLINICAL OBSERVATIONS

Dr. Stucky, after many years of work among the mountain people of Kentucky, reached the following conclusions: (1) In a mountain institution where many children were living he observed

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that acute inflammatory conditions of the nose and throat appeared after celebration of a holiday, such as Christmas. This he felt was due to candy and other sweets which were furnished at the time. By substituting bananas, apples, and oranges for the sweets, these post festival inflammatory conditions of the nose and throat no longer appeared. (2) He also noted that enlarged tonsils and adenoids were related to an excess of carbohydrate in the diet.

TABLE I

GENERAL CAUSES OF RED AND PALE NASAL SEPTUM

RED	PALE
Acid ash foods.	Alkaline ash foods.
Administration of mineral acids.	Iodine in food or administered.
Physical fatigue.	Hypo—glandular activity.
Infection.	
Overactive adrenal and thyroid.	

ACID-BASE BALANCE

TABLE II

ACID PRODUCING FOODS

EGG YOLK	HALIBUT, FRESH
OYSTERS, FRESH	TROUT, SALMON
SHREDDED WHEAT	CRACKERS, SODA
OATMEAL	WALNUTS
SARDINES	BREAD, WHOLE WHEAT
EGGS, WHOLE	BREAD, WHITE
BEEF, PORTERHOUSE	PERCH
CHICKEN	CORN
SALMON, CANNED	CHEESE, CHEDDAR
BARLEY, PEARL	LENTILS
PORK, LEAN	BACON
VEAL, LOIN	EGG WHITE
HAM, SMOKED	PEANUTS
BEEF, RIBS, LEAN	CORN, GREEN
MUTTON, LEG	#CRANBERRIES
RICE	#PRUNES

#The ash of these foods is alkaline in nature, but because of the unoxidizable acid contained by them, they increase the acidity of the body.

ACID-BASE BALANCE

TABLE III

ALKALI PRODUCING FOODS

MOLASSES	SWEET POTATOES
RAISINS	PLUMS
BEANS, FRESH LIMA	CABBAGE
ALMONDS	x BANANAS
PARSNIPS	x ORANGES
DATES	TOMATOES
BEETS, FRESH	LEMONS
CARROTS	BEANS, STRING, FRESH
FIGS	PEACHES, FRESH
RUTABAGAS	MUSHROOMS
CUCUMBERS	GRAPEJUICE
CELERY	x APPLES
x MUSKMELON	PEARS
LETTUCE	RADISHES
x POTATOES	MILK, WHOLE
COCOANUTS	ONIONS
PINEAPPLE, FRESH	PEAS, FRESH

xThese foods have been found experimentally by Blatherwick to be the most efficient in reducing the acidity of the body.

MUCOUS MEMBRANE COLOR CHANGES

While one may study the mucous membrane in other parts of the body, that covering the cartilaginous portion of the nasal septum has been selected, because it is always accessible and is more sensitive to changes in body chemistry than mucous membrane elsewhere.

You will note that acid foods are foods *not* ripened by the sun, while alkaline-ash foods are foods that *are* ripened by the sun, with the exception of milk and molasses both of which originate in the vegetable kingdom.

Under the acid producing foods are listed animal foods and cereal grains with their products, with most of which either in the preparation or in the serving, sodium chloride is used. The alkaline list furnishes more organic iodine while the acid foods supply more chlorine.

CHEMICAL BALANCES

Acid-Alkaline—The acid-alkaline balance has already been sufficiently referred to, for the purpose of this presentation, in the discussion of alkaline and acid-ash foods.

Sodium-Potassium—According to Harrup ("Diet in Disease" pg. 29, Blakeston, 1930), sodium exists in the blood almost to the exclusion of potassium, but potassium predominates in blood cells, tissues, and milk. Larger amounts of sodium are eliminated when intake of potassium is increased. In salt deprivation, man and animal show less inclination to take vegetables rich in potassium. Shinzo found a condition similar to beri-beri in rabbits when they were given an excess of sodium, which was cured by the administration of potassium carbonate. These observations indicate a sodium-potassium balance in the body. There are other chemical balances in the body recognized by the group which lack of time prevents mentioning.

SYMPATHETIC PARA-SYMPATHETIC EQUILIBRIUM

The autonomic nervous system is composed of two divisions, the sympathetic and the parasympathetic. The sympathetic system is catabolic in nature while the para-sympathetic is anabolic. Thus, in the liver, glycogen is stored by parasympathetic action while sympathetic stimulation mobilizes the glycogen into the blood stream as glucose.

Clinical observation has led the group to believe that a red septum indicates sympathetic dominance and a pale septum para-sympathetic dominance, *provided* that the septal color is not influenced by local pathology. Thus we see the thought of the group shifting from acid-ash and alkaline-ash foods as the cause of the red and pale septum, to that of sympathetic and para-sympathetic dominance. When the sympathetic is domi-

TABLE IV

AUTONOMIC STATUS						
ACIDOSIS LEVEL—LEVEL OF COLLAPSED RESISTANCE—DEATH						
Infectious Zone	Dominant Sympathetic Vaso-Dilatation	Red	Excess Acid From 1. Acid Foods. 2. Mineral Acids. 3. Physical Fatigue. 4. Deficient Elimination From Skin and Kidney.	Excess Sodium and Chlorine Deficient Potassium and Iodine	Potential Diabetic. Deficient in Insulin	Excess Secretion
Symptom-Free Zone	Balanced Vaso-Motor Status	Mucous Membrane Color	Acid Base Balance	Sodium-Potassium Balance	Normal Pancreatic Secretion	Normal Thyroid, Para-Thyroid Anti-Pituitary, Suprarenal.
Allergic Zone	Dominant Para-Sympathetic Vaso-Constriction	Pale	Excess Alkali	Deficient Sodium and Chlorine Excess Potassium and Iodine	Excess Insulin If Long Continued Pancreatic Exhaustion	Deficient Secretion
ALKALOSIS LEVEL—LEVEL OF MULTIPLE TOXIC SUBSTANCES—DEATH						

nant the patient is likely eating meats, eggs, fish, salt or sweets, to excess, has a red nasal septum, and often suffers repeated infections.

On the other hand, the nasal septum is pale when the para-sympathetic is in the ascendency. These patients are not so susceptible to infections, but are prone to develop allergic manifestations, such as itchy skin, angioneurotic edema, eczema, asthma, hay-fever, hives and digestive disturbances. They often have catarrhal "colds", but these colds are primarily vaso-motor disturbances with eosinophiles instead of poly-morphonuclears predominating in their nasal secretions, even though infection may become superimposed. They usually eat little meat, eggs, fish, salt or sweets but are fruit and vegetable eaters. According to the chart of Dr. Blackmar (Table IV), we see that the factors tending to shift the autonomic level are: acid-base ingestion ratio, the sodium-potassium equilibrium, fluid intake, chlorine-iodine balance, and endocrine equilibrium.

The top of the chart represents sympathetic dominance, brought about by excess intake of acid over alkali, sodium over potassium, chlorine over iodine, or the secretions of the supra-renal, thyroid and pituitary glands over that of the pancreas.

Between the infectious and allergic zones is the symptom free zone, in which these various factors are in normal relationship.

The group realizes, of course, the imperfectly understood inter-relationship between the endocrine secretions and the autonomic nervous system, so regard this chart of Dr. Blackmar's as a helpful formula in clarifying thought, subject to change whenever additional data is presented. This added approach to the understanding of disease has often aided, both in its diagnosis and treatment. For the group study has emphasized from the first the dual nature of infection, namely, the host and the invading organism.

Dr. Jarvis early insisted upon the importance of preventing ever-present germ infestation becoming infection.

And whatever one may think of the present correlation of the group regarding chemical balances or sympathetic, para-sympathetic, and endocrine equilibrium, clinical improvement often is achieved by the additional measures which this group has developed.

AUTHOR'S SERIES OF OBSERVATIONS

It has been my privilege to have access to this group correspondence and to apply to the practice of pediatrics some principles subscribed to by this group. At this time I wish to present my clinical experience with these principles.

For the past two years the writer has included in the examination of all infants and children an inspection of the nasal septum and recorded its color, to determine, if possible, the meaning of nasal septal color in children.

Investigation began with new-born infants. Attention was quickly arrested by seeing uniformly pale septums, so observations were continued over a two year period, in order to exclude the seasonal factor as well as to confirm or disprove the early findings.

New born infants, in successive groups, of approximately 16 each, were examined at the Lucas County Hospital. Their ages varied from a few hours to 29 days, the average being about 7 days. The small nares and nasal passages made observations difficult in some instances, but with good illumination by otoscope (without the speculum), correct observations were possible.

TABLE V

OBSERVATIONS OF THE COLOR OF THE NASAL SEPTUM IN 302 NEW BORN INFANTS

Number	Type	Septal Color		
		Red	Neutral	Pale
258	White	4	3	251
44	Colored	0	6	38
148	Males	4	5	139
154	Females	0	4	150
263	Breast	2	8	253
39	Formula	2	1	36

In this series of 302 new-borns, 289 showed a pale septum, 9 a neutral septum, and 4 a red septum, two of the latter dying of pneumonia. The table shows that sex, race, or type of feeding have no appreciable effect on the color of the septum in the new-borns.

TABLE VI

OBSERVATIONS ON 730 CHILDREN, EXCLUSIVE OF NEW-BORNS, TABULATED ACCORDING TO AGE

Age Group	Red Sept.	Neutral	Pale
Under 1 year of age.	24	21	138
1 to 2 years	19	3	44
2 to 3 years	26	6	17
3 years and over.	325	74	33

We have seen that the age factor accompanies the practically uniform finding of the pale septum in the new-born. This factor gradually diminishes until after three years of age when other factors become operative. If the sympathetic nervous system is associated with a red nasal septum and among its functions it stimulates the aggressive, defensive, and catabolic mechanisms in the body, may it not be that the pale septum of early life but reflects the protective care usual at that time, and that the para-sympathetic associated with a pale septum and with anabolic activity, is found dominating.

Viewing the observations now from the standpoint of correlating septal color with disease we find that the available figures are not sufficiently large to be decisive, but some are presented which may show trends.

TABLE VII

SEPTAL COLOR AND DISEASE

Disease	Septal Color		
	Red	Neutral	Pale
Upper Respiratory Infection.	92	17	39
Allergic Manifestations.	8	6	37
Extra-pulmonary Tuberculosis.	25	5	2
Encephalitis.	6	4	0
Chorea.	10	0	0
Pneumonia.	5	0	6
Typhoid.	7	1	0

In the above analysis the pale septum predominates only in the allergic manifestations while in infectious diseases the larger figures are seen under the red septum. This in a measure supports the chart on the autonomic level, which shows the allergic manifestations, pale septum, and para-sympathetic dominance as connected, while the infections, red septum, and sympathetic dominance are associated.

CASE HISTORIES

Two cases are briefly reported, one exhibiting a pale septum, the other a red septum.

Case 1.—W. S. Male, age 3 months, admission to hospital April 12, 1934; diagnosis, chronic eczema.

Past History—Nothing abnormal except has regurgitated since birth and rash has been present since one month of age.

Physical Examination—Well developed, thin, wiry boy baby with extensive eczematous lesions on scalp, face, neck, and arms, with scratch marks. There were no other lesions. He was given the usual treatment, simple milk dilutions with Karo syrup then Sobee for three weeks, then simple dilutions again plus cereal. Locally 10 per cent tar ointment, boric acid ointment, and taroxide ointment. On May 19th, five weeks after admission, when I first examined him, the eczema had improved somewhat though there were many papulo-vesicular and scaley lesions and scratch marks (the hands had to be restrained), and his nasal septum was very pale.

Treatment:—No change was made in diet or local applications but 20 per cent HCl, 2 drops t. i. d., was ordered. When seen eight days later the skin was much improved and it was no longer necessary to restrain his hands. The septum, however, was still very pale, so HCl drops, were increased to three drops t. i. d. June 11th, the skin had cleared all but one small spot on scalp, the septum was still pale, so the HCl drops were increased to four, t. i. d., alternating every other day with three drops, t. i. d. The patient was next seen eight days later, June 19th, when nurses reported that the skin had become clear four days before, and remained so for two days, then pimples appeared on the cheeks. Examination showed bright red, papular lesions on cheeks and arms

but no scratching. Was about to again increase the HCl drops, but was deterred by finding a red septum. The HCl was discontinued on the theory that its prolonged use had, by the law of halogen displacement, set free, stored iodin into the blood stream, and that these new lesions were evidence of iodism.

June 22—three days later, this rash was much improved and nasal septum had lost some of its redness. In another few days the skin became and remained normal, and the nasal septum was a normal pink color.

Case 2.—Boy 14 years, on December 24, 1933, the 15th day of a severe attack of scarlet fever, developed ear ache in left ear which began discharging. Four days later cervical glands became greatly swollen and left ear was discharging freely; boric acid ear wash and 2 per cent iodine ointment to glands were ordered. On January 13, 1934, he consulted an ophthalmologist because he could not see to read well—felt as if there was a film over the eyes. Examination at that time "Showed a very anemic, mouth-breathing child, with no gross fundus lesions in the eye. The throat showed the pillars and naso-pharynx covered with a muco pus, coming from both nostrils—the left ear had a red drum which was bulging and there was pus on the posterior canal wall with perhaps a small opening in the drum." Two days later January 15th, "Left ear was incised to allow better drainage."

On February 7th, 1934, the writer was called to see this patient who presented a generalized erythemato-macular rash (diagnosed, "toxic erythema"), a discharging left ear, and tender left mastoid. The nasal septum was distinctly red. Diagnosis:—Post-scarletinal otitis and mastoiditis. Treatment:—(1) Tincture of iodine 3 drops with sod. bicarbonate 1 teaspoon, t. i. d., for three days. (2) Cod liver oil, 1 teaspoon, t. i. d., Mead's cereal once a day, spintrate 1 teaspoonful daily, and a diet in which the alkaline ash foods were stressed. (3) At the end of three days the iodine and sodium were stopped and dilute hydrochloric acid, substituted in 5 drop doses, t. i. d., for three days, when iodine and sodium bicarbonate were alternated every three days with the HCl.

Ten days later note by otologist "the left ear was still discharging freely but the mastoid tenderness had disappeared."

As the otologist still feared that mastoid operation would be necessary, an *X*-ray was taken and reported as follows:—"Left mastoid a little clouded below but no breaking down of cells, and the right mastoid very sharp with cells very thin near center." So operation was avoided in this case, as boy went on to complete recovery.

SUMMARY

1. Nasal septum of newborn infants is, as a rule, pale.

2. A study of age groups shows that with increase of age comes increased number of children showing a red mucous membrane.

3. A comparison of nasal septum mucous membrane color with clinical illness shows that a red mucous membrane child is apt to develop infections while one with a pale mucous membrane is apt to manifest allergy.

4. As for treatment, some form of iodine when the mucous membrane is red and some form of chloride when the mucous membrane is pale, seems to bring clinical improvement.

2228 SCOTTWOOD AVE.

DISCUSSION

E. G. HORTON, M.D., Columbus: Mr. Chairman and members of the section: Sometimes we see strange results. Elsewhere in this state meeting, I have listened to three papers on time-worn subjects treating in the main phases well known for years. The discussions were vigorous if not new. Now we have just listened to this splendid paper by Dr. Giffen, and I venture to say it opens up a field, new to many of us and we wonder just where we are and how much of it is really so. We certainly want to compliment the essayist on his paper and the work it has involved, and thank him for the presentation which has been so interesting. It was not my privilege to be one of the forty and ten who have been corresponding on this phase of work, and but very recently has some knowledge come to me on the subject. In the brief time at hand I have been checking up as much as possible, and it seems that the things stated by Dr. Giffen are facts, and we find no cause for even intimating he is a prevaricator or dreaming. Sometimes some physicians are prone to differ with another physician rather than to agree with him, especially if he is advocating something new. It seems to me the data furnished by the essayist in this paper is going to be of help to us, and will benefit our patients when applied, in which case we will be more appreciative and thankful after absorbing more of the teachings just presented.

—OSMJ—

NEW BOOKS

Synopsis of Genitourinary Diseases, Austin I. Dodson, M.D., Richmond, Va., professor of genitourinary surgery, Medical College of Virginia; treatise summarizing the prominent signs and symptoms of urogenital diseases; technic of physical examination; instruments needs in general practice and their uses; description of anatomy of genitourinary organs, etc.; C. V. Mosby Company, 3523 Pine Boulevard, St. Louis; publishers; price, $3.00.

Nursing Schools—Today and Tomorrow, final report of the Committee on the Grading of Nursing Schools; Nursing Information Bureau, American Nurses' Association, 50 West 50th Street, N. Y., publishers; price, $2.00.

To Remind, by Sir William Bate Hardy, D.Sc., Cambridge, England; a biological essay; series No. 2 of the Abraham Flexner Lectures given at the School of Medicine, Vanderbilt University.

The Principles of Therapeutics, by Francis Richard Fraser, M.D., professor of medicine, University of London; series No. 3 of the Abraham Flexner Lectures given at the School of Medicine, Vanderbilt Univeristy.

—OSMJ—

Cincinnati—Dr. Walter E. List, superintendent of Jewish Hospital, Cincinnati, has been elected a trustee of the American Hospital Association for a three-year term.

THE PRESENT STATE OF INDIVIDUAL PREVENTIVE MEDICINE

By AUGUSTUS A. HALL, M.D.,

Columbus, Ohio

REALIZING the need for a more comprehensive view of the efforts being made by various supporters of the periodic health examination movement we have assembled here a group of facts that we hope will shed more light on this important phase of preventive medicine.

This data was gathered between July 1933, and February 1934, from three principal sources—state and territorial medical organizations, state and territorial public health organizations, and medical colleges. The literature on the subject was reviewed covering the last seven years—not exhaustively, but we feel adequately.

LITERATURE

The literature relative to the periodic health examination during the past seven years is very interesting and is a fair barometer of the national medical thought on the subject. Most authorities agree that the examination is worth while, that the general practitioner is the person most suitable to give the examination, that a form is necessary to avoid omission, adequate time should be allotted the patient, and hygiene should be emphasized as well as correction of detected defects.

One of the apparently debatable questions concerning this examination is a clear definition of what it should include and its practical limitations. The prevailing policy has been to use the American Medical Association examination form as a standard.

Armstrong[1], Brooks[2], and Bloedorn[3] emphasize the fact that this is not a panacea for all ills but is the present practical application of preventive medicine. Harris[4] says we should concentrate more towards increasing health and happiness than longevity alone. Bryant[5] stresses the importance of educating the public and the profession along the lines of practical preventive medicine.

Rowland[6] reminds us that with every new advance in medicine there is either passive or active resistance or both from a part of the profession. This is traditional and we have only to recall the opposition Holmes, Lister, and Harvey experienced to their beliefs and teachings. C. E. A. Winslow's "The Life of Hermann M. Biggs", eloquently describes this resistance to the advance of new public health ideas and principles, such as the establishment by Dr. Biggs of compulsory notification of tuberculosis in New York.

Brooks[7], Welch[8], Tidmarsh[9], Bauer[14], Faught[10], Martin[11], and Rowland[6] assert that the reaction of the profession to this movement is in a more or less lethargic state and proper interest is not being attached to this examination.

Liber[12], Faught[13], and Rowland[6] warn the profession that unless we arouse and assume our responsibilities of individual preventive medicine, other agencies will take it over—for, according to Tidmarsh[9], the public demand for this service is increasing.

SURVEY

1. *State and Territorial Medical Organizations.* Fifty-two associations were written to throughout continental United States and the Territorial Possessions. Forty-two replies were received, or 80 per cent. Chart I shows the results of the inquiry. It will be seen that twenty, or 48 per cent of the organizations, have participated in the movement. Ten, or 50 per cent of those participating, distributed literature describing the periodic health examination.

Nebraska, New Jersey, New York, and South Dakota have a definite state program. Michigan, New Jersey, Pennsylvania, and Wisconsin have issued cards to be hung in physicians' offices announcing the examination.

The results of this part of the survey are illuminating and optimistic. Considering the period of the survey as the pit of the depression the fact that practically half of the state and territorial medical organizations are participating in the movement is encouraging.

2. *State and Territorial Public Health Organizations.* Fifty-two state and territorial public health organizations were contacted and forty-three inquiries were answered, or a return of about 83 per cent. Chart II shows the result of this part of the survey. Only seventeen or 40 per cent indicated that they had a definite program for the furtherance of the periodic health examination movement. Sixteen or 37 per cent had cooperated with the medical organizations of their district at some time or other in promoting this cause. Thirty-three or 77 per cent have participated in some fashion in the movement. The interest indicated towards the periodic health examination is noteworthy. Seventeen or 40 per cent were passive, five or about 12 per cent were fair, nineteen or 45 per cent were active, and two indeterminate. All but five indeterminate replies

Chairman Periodic Health Examination Committee, Columbus Academy of Medicine.

CHART I

STATE AND TERRITORIAL MEDICAL ORGANIZATIONS

	Participation in Movement	Distribution of Literature	Publicity over Radio, Speakers, Press, etc.	Public Campaigns	Furnished Office Cards
1. Alabama	No	--	--	--	--
2. Alaska	No*	--	--	--	--
3. Arizona	No	--	--	--	--
4. Arkansas	Yes	Yes	--	--	--
5. California	No	--	--	--	--
6. Colorado	Yes	State	no interest among prof.		
7. Delaware	No	--	--	--	--
8. District of Columbia	Yes	Yes	Yes	No	No
9. Florida	No	--	--	--	--
10. Georgia	Yes	--	Yes	--	No
11. Idaho	No	--	--	--	--
12. Indiana	Yes	Yes	Yes	No	No
13. Illinois	Yes	Yes	--	--	Pending
14. Iowa	Yes	No	Yes	No	No
15. Kansas	No	--	--	--	--
16. Louisiana	No	--	--	--	--
17. Maine	No	--	--	--	--
18. Maryland	No	--	--	--	--
19. Massachusetts	Yes	Yes	Yes	--	--
20. Michigan	Yes	--	--	--	Yes
21. Minnesota	No	--	--	--	--
22. Mississippi	Yes	Yes	--	--	--
23. Missouri	No	--	--	--	--
24. Nebraska	Yes	No	--	Yes	--
25. New Hampshire	Yes	Yes	--	--	--
26. New Jersey	Yes	--	Yes	Yes	Yes
27. New Mexico	No	--	--	--	--
28. Nevada	No	--	--	--	--
29. New York	Yes	--	Yes	Yes	--
30. North Carolina	No	--	--	--	--
31. North Dakota	No	--	--	--	--
32. Pennsylvania	Yes	--	--	--	Yes
33. Philippine Islands	No	--	--	--	--
34. Rhode Island	No	--	--	--	--
35. Ohio	Yes	No	Yes	No	No
36. South Dakota	Yes	Yes	May Day Program		
37. Tennessee	Yes	Yes	--	--	--
38. Texas	Yes	Yes	No	No	No
39. Virginia	No	--	--	--	--
40. Washington	No	--	--	--	--
41. West Virginia	No	--	--	--	--
42. Wisconsin	Yes	No	Yes	No	Yes

(The mark -- in a space does not indicate a negative but a lack of information.)

* The Alaska Organization is so widely scattered that this work is impossible at the present time.

approved the principle of the periodic health examination.

To summarize, the public health associations unanimously approve the periodic health examination, most of them have participated in the movement—some passive, a few fair, and some active—and about a third have cooperated with organized medicine.

Some added individual notes from various active states are of interest. The Kansas State Board of Health states that the only sections where much progress has been made is in the counties operating full time health departments. From the Kentucky State Board of Health we were pleased to hear that "I am sure from reports that have reached us that the periodic health examination is slowly but surely gaining ground". Kentucky has full time health officers in 80 out of 120 counties.

In Nebraska and New Mexico the movement died from lack of interest of laity and profession in the former, and profession mostly in the latter. For the past thirteen years the New York Department of Health has conducted an annual physical examination of its employes. They say—"Each year a larger percentage take advantage of the service and a greater interest is apparent in

CHART II

STATE AND TERRITORIAL PUBLIC HEALTH ORGANIZATIONS

	Have a State Program	Have Cooperated with Medical Organization	Participated in Movement	Interest Towards Movement	Approve of Movement
1. Alabama	No	No	None	Passive	Yes
2. Arkansas	No	Yes	Yes	Passive	Yes
3. California	No	--	Yes	Passive	Yes
4. Connecticut	Yes	Yes	Yes	Active	Yes
5. Delaware	No	No	Yes	Passive	Yes
6. District of Columbia	No	No	No	Passive	Yes
7. Florida	No	No	Yes	Fair	Yes
8. Georgia	Yes	Yes	Yes	Active	Yes
9. Idaho	No	No	No	Passive	--
10. Indiana	No	No	No	Passive	--
11. Iowa	Yes	No	Yes	Active	Yes
12. Kansas	Yes	Yes	Yes	Active	Yes
13. Kentucky	Yes	Yes	Yes	Active	Yes
14. Louisiana	Yes	No	Yes	Active	Yes
15. Maine	No	No	Yes	Passive	Yes
16. Maryland	Yes	No	Yes	Active	Yes
17. Massachusetts	Yes	Yes	--	Active	Yes
18. Michigan	No	No	No	Passive	Yes
19. Minnesota	Yes	Yes	Yes	Active	Yes
20. Mississippi	Yes	--	Yes	Active	Yes
21. Nebraska	No	Yes	Yes	Passive	--
22. Nevada	No	No	Yes	Passive	Yes
23. New Mexico	No	No	Yes	Active	Yes
24. New Jersey	No	No	No	Passive	Yes
25. New York	Yes	Yes	Yes	Active	Yes
26. North Carolina	Yes	Yes	Yes	Active	Yes
27. Ohio	No	No	Yes	Passive	Yes
28. Oklahoma	No	No	No	Passive	--
29. Oregon	Yes	Yes	Yes	Active	Yes
30. Pennsylvania	No	--	Yes	Fair	Yes
31. Rhode Island	No	No	No	--	--
32. South Dakota	No	No	Yes	Fair	Yes
33. Tennessee	No	Yes	Yes	Fair	Yes
34. Texas	No	Yes	Yes	Passive	Yes
35. Utah	No	No	No	Passive	Yes
36. Virginia	No	No	Yes	Fair	Yes
37. Washington	No	Yes	Yes	Active	Yes
38. West Virginia	No	No	Yes	Passive	Yes
39. Alaska	Yes	Yes	Yes	Active	Yes
40. Panama Canal Zone	Yes	Yes	Yes	Active	Yes
41. Philippine Islands	Yes	No	Yes	Active	Yes
42. Porto Rico	No	No	Yes	Active	Yes
43. Virgin Islands	Yes	--	Yes	Active	Yes

(The mark -- in a space does not indicate a negative but a lack of information.)

carrying out the recommendations of the examiner."

In North Carolina a campaign was conducted by Dr. Frederick R. Taylor, F.A.C.P.[15], and sponsored by the North Carolina Board of Health. Dr. Taylor reported 436 periodic health examinations made during demonstrations in 51 counties. There were 1,555 defects found—an average of 3.57 per person and there were 259 varieties of defects. This data tallies closely with results of a survey made on Chicago school children.

J. F. Siler, Chief Health Officer of the Panama Canal Zone, says:—"I think it may be said without exaggeration that this community as a whole is much more public health minded than is the average community. As a result much larger than the average number of individuals take advantage of the facilities offered them in having physical surveys made from year to year."

Dr. Jacob Fajardo, Director of Health, Philippine Islands, writes that during 1933 478,775 pupils were given periodic health examinations. Every school child is examined four times during school life.

The record of practical preventive medicine in the Virgin Islands is enviable. Dr. Knud Knud-Hansen, Commissioner of Health says:—"In the Virgin Islands we have for the past 30 years at least had no case of diphtheria, scarlet fever or rickets, and from 1917 to 1934 have seen only four cases of typhoid fever."

3. *Medical Colleges.* We sent inquiries to all

CHART III

MEDICAL COLLEGES CLASS A-1
FOUR YEAR COURSE
CONTINENTAL UNITED STATES

		Chair of Preventive Medicine	Is Periodic Health Examination Stressed	Taught in One Course	Special Courses	Good Clinical Experience
1.	University of Arkansas	Yes	No	--	--	--
2.	College of Med. Evangelists—Cal.	No	--	--	--	--
3.	Stanford University	Yes	Yes	Yes	No	--
4.	University of California	Yes	Yes	--	Yes	--
5.	University of Southern Cal.	No	No	No	Yes	--
6.	University of Colorado	No	No	--	Yes	--
7.	Yale University	Yes	Yes	No	No	Yes
8.	Georgetown University	Yes	No	--	--	--
9.	Howard University	Yes	Yes	--	--	--
10.	Emory University	No	Yes	No	No	Yes
11.	University of Georgia	Yes	No	Yes	No	No
12.	University of Illinois	Yes	No	Yes	No	--
13.	University of Chicago	No	Yes	Yes	No	--
14.	University of Indiana	Yes	Yes	Yes	No	--
15.	University of Iowa	Yes	Yes	Yes	No	Yes
16.	University of Kansas	No	No	No	Yes	--
17.	Tulane University	Yes	Yes	Yes	No	Yes
18.	University of Maryland	Yes	Yes	Yes	No	Yes
19.	Johns Hopkins University	No*	No	--	--	--
20.	Tufts College	Yes	Yes	Yes	No	--
21.	Harvard University	Yes	Yes	Yes	No	--
22.	Boston University	Yes	Yes	--	--	--
23.	George Washington University	--	No	--	--	--
24.	University of Michigan	Yes	Yes	Yes	No	--
25.	Detroit College of Medicine	Yes	Yes	Yes	No	--
26.	University of Minnesota	Yes	Yes	Yes	No	Yes
27.	Washington University	No	No	--	--	--
28.	Creighton University	Yes	Yes	Yes	No	--
29.	University of Nebraska	No	No	No	No	--
30.	Union University—Albany	No	No	--	--	--
31.	Columbia University	Yes	Yes	No	No	--
32.	Cornell University	Yes	No	Yes	No	--
33.	Syracuse University	Yes	Yes	No	No	--
34.	New York University	Yes	Yes	No	Yes	Yes
35.	Long Island College Medicine	Yes	Yes	No	No	Yes
36.	New York Homeopathic	No	No	--	--	--
37.	Duke University	No	No	No	No	--
38.	University of Cincinnati	Yes	No	--	--	Yes
39.	Western Reserve University	No	Yes	No	No	--
40.	University of Oklahoma	No	No	--	--	--
41.	University of Oregon	No	No	--	--	--
42.	Women's Medical College	Yes	Yes	Yes	Yes	Yes
43.	Hahneman—Phila.	No	No	--	--	--
44.	Jefferson	Yes	Yes	--	--	--
45.	University of Pittsburgh	Yes	Yes	--	--	--
46.	University of Pennsylvania	Yes	Yes	Yes	No	Yes
47.	Temple University	No	Yes	No	Yes	--
48.	Ohio State University	No	No	--	--	--
49.	Med. Col. of South Carolina	No	No	--	--	--
50.	Meharry Medical College	Yes	Yes	--	--	--
51.	University of Texas	Yes	No	--	--	--
52.	Baylor University	Yes	Yes	--	--	--
53.	Vermont University	Yes	No	Yes	No	--
54.	University of Virginia	Yes	Yes	--	--	--
55.	Medical College of Virginia	Yes	Yes	--	--	--
56.	Rush Medical College	No	Yes	--	--	--
57.	Marquette University	No	No	No	No	--
58.	University of Wisconsin	Yes	Yes	--	--	--

(The mark -- in a space does not indicate a negative but lack of information.)

* Students receive instruction from members of the faculty of the School of Hygiene and Public Health.

medical colleges rated class A-1 in 1933 and having a four year course—a total of 66 colleges—and received replies from 56 or 88 per cent. This particular part of the survey has to do with the very foundation of individual preventive medicine from the professional standpoint. Let us view the situation as it exists today.

Thirty-five or about 63 per cent have a functioning chair of preventive medicine. In only 31 or 55 per cent is the periodic health examination stressed in the curriculum. Voluntary information received from 31 colleges shows that the periodic health examination is taught in one department in nineteen. Of 32 colleges replying we find that eight have special courses on the periodic health examination. Thirteen colleges mentioned that they provided good clinical experience for medical students in making these examinations.

We may sum up this data by saying that two-thirds of the colleges have a chair of preventive medicine, about half of the colleges stress the periodic health examination—and in this same number mentioned last the subject is taught under one department.

COMMENT

When we realize that the first practical steps taken in this movement only date back to the founding of the Life Extension Institute in 1914, the evidence of activity shown by this survey in these three fields alone is quite encouraging. The gradual displacement of the curative side of practice with individual preventive medicine, within certain limitations, is recognized today. Most authorities sponsoring this phase of practice do not assume that all disease will eventually be prevented. Neither do they take the attitude of the recent conclusions of the Massachusetts Medical Society's committee on public health who state that periodic health examinations are a luxury. They present two charts, one for males and one for females, showing the proportionate mortalities at various ages in Massachusetts from 1930-1932. If one eliminates the deaths from pneumonia, accidents, suicide, arteriosclerosis and cerebral hemorrhage, all of which constitute roughly one-third of the deaths, and practically none of which we presume to prevent at the present time, you will see that we have left cancer, heart disease, nephritis, tuberculosis, appendicitis, prostate, and all other causes of death. These are definitely within the realm of possibility and a good percentage are practical now.

We must not forget that the periodic health examination is only the practical symbol of individual preventive medicine—an understandable method of serving the public. Even if the periodic health examination in its present form should cease to exist, another more applicable method to serve the furtherance of individual preventive medicine will arise. A service to humanity of such importance as the prevention of disease in the individual will become more and more in demand by the laity as they become more and more enlightened. Such service is as valuable, within its limitations, as the curative side of practice and should be equally compensated.

Finally we suggest that much more progress could be made if there were closer cooperation between medical associations, public health associations, and the medical colleges.

Many private enterprises and the military services are furthering this examination—notably the Gorgas Memorial Institute, the National Health Council, the International Health Board, the Army and Navy, and others. A unification of this effort seems the most logical step to attain in the near future.

CONCLUSIONS

1. A survey was made of the present state of the periodic health examination movement in the state and territorial medical organizations, state and territorial public health organizations, and medical colleges of continental United States.

2. The literature during the past seven years shows a general approval of the examination, a fair state of disinterest among a large percentage of the profession, and warns the profession of the real danger of this service being lost to organized medicine from lack of interest.

3. A survey of the state and territorial medical organizations reveals that half have participated in the movement.

4. Evidence gathered from state and territorial public health organizations shows that about 40 per cent had a definite program and 77 per cent had participated in the movement.

5. Data received from the medical colleges disclose the fact that 63 per cent have a functioning chair of preventive medicine and the periodic health examination is stressed in 55 per cent.

6. Progress in the periodic health examination movement in these three fields is encouraging.

7. Excluding the accidental deaths the periodic health examination is a real factor in preserving health and increasing longevity.

8. A unification of existing sources of effort should be the next logical step in the establishment of this important phase of preventive medicine.

2483 EAST MAIN STREET.

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RACHITIC DWARFISM WITH NEPHROSIS*

(With Reference to Renal Rickets)

By I. H. KASS, MD.,
TOLEDO, OHIO

and E. J. HUENEKENS, M.D.,
MINNEAPOLIS, MINNESOTA

THE syndrome known as renal rickets, or renal dwarfism is a condition characterized by retardation of body development, rachitic changes in the bones, and is usually accompanied by chronic kidney disease in early life. Clinically, there appears to be little to differentiate the rachitic changes in the bones from those observed in ordinary infantile rickets. There is a difference of opinion as to the specificity of the roentgenologic and histologic findings in the bones[1, 2, 3, 4], but it is generally accepted that these changes in renal rickets are hardly distinguishable from, and are even identical with, those seen in the usual case of rickets.

Of the 53 cases of renal rickets reviewed by Hunt[5], 54 per cent reported the postmortem findings. The renal lesions include granular atrophy or chronic parenchymatous nephritis[6], chronic suppurative changes[7, 8, 9], congenital defects[10, 11], urinary tract obstructions[12, 13], and other abnormalities which give rise to a renal insufficiency. The actual cause of renal rickets is not definitely known. The metabolic disturbances, dwarfism, and rachitic changes in the bones have been ascribed to the effects of a renal insufficiency.

One of the theories is that the kidney damage causes a retention of phosphorous in the blood stream, and that this in turn depresses the ionization of calcium. The only difficulty about this theory is that not all cases of renal rickets show this retention of phosphorous. Mitchell[6], states that with an increased concentration of the phosphates in the intestinal tract as a result of inability of the kidneys to excrete such products, there may be an interference with the absorption of calcium, presumably through the formation of insoluble calcium phosphate. The body would, therefore, suffer a true calcium starvation.

In 1930, there came to our attention, a child with definite retardation in growth and development, marked rachitic changes in the bones, failure to respond to anti-rachitic therapy, and with kidney findings unlike those reported in previous discussions on the subject of renal rickets or renal dwarfism.

REPORT OF CASE

History: Baby B. W., female, 20 months of age, was first seen on March 5, 1930. The chief complaints were poor appetite and rickets.

The family history was unimportant. The infant's birth history was normal and her birth weight was 8 pounds. The parents were in good health. A brother of the patient had died in infancy of encephalitis. One sister and one brother, 8 and 10 years of age respectively, were living and well.

The infant had one moderately severe upper respiratory infection at 8 months and measles at 10 months. She was breast fed for 5 months, and then given cow's milk mixture and cereals. Orange juice was begun at 2 months of age. At 10 months, she was given cod liver oil in the form of a cod liver oil and iron mixture and received 2 teaspoonsful daily of this prescription. The diet had been essentially a normal one but the infant's appetite was very poor. She appeared to gain in weight normally up to the 10th month. The first tooth appeared at 6 months of age; she stood alone at 14 months but never walked alone. She talked at 17 months.

Present Illness: Following a severe attack of measles at 10 months of age, the infant's appetite became very poor and she gained little in weight. She had recurrent attacks of vomiting; no diarrhea; no fever. The parents were concerned about the infant's failure to walk alone and her rachitic tendencies.

Physical Examination: The infant was markedly undernourished and underdeveloped. Her weight was 8,105 grams. There were signs of severe rickets. The anterior fontanelle was wide open and the bossae of the skull were prominent. There were marked beading of the ribs; Harrison's groove; and a definite enlargement of the epiphyses at the wrists and ankle joints. The infant had 12 teeth. There was a severe aphthous stomatitis and the tonsils appeared subacutely

*From the Section of Pediatrics, Mayo Clinic, Rochester, Minnesota, and the Abbott Hospital, Minneapolis, Minnesota. Presented at the Staff Meeting of the Women's and Children's Hospital, Toledo, Ohio, April 10, 1934.

inflamed. The heart and lungs were normal. The abdomen was essentially negative. The neurological findings were normal.

Course: A well balanced diet was outlined for the infant, cod liver oil, 1 teaspoonful three times daily, and viosterol, 10 drops three times a day, were prescribed. After a stay at home of 17 days, she was again seen on March 22, 1930. At this time, she weighed 8,170 grams, a gain of 65 grams. When re-examined on April 10, 1930, the infant had gained 50 grams. On April 19, 1930, the infant weighed 7,930, a loss of 290 grams since the last visit. Her appetite had not improved.

Because of the appearance of the tonsils and adenoids, it was thought that the infant's appetite and weight were influenced by a more or less chronic upper respiratory infection. A tonsillectomy and adenoidectomy were performed at Abbott Hospital on April 20, 1930. The patient remained in the hospital for 23 days and made an uneventful recovery. During this period, attempts were made to improve the infant's nutrition. Because of her persistent lack of appetite, she was forcibly fed during the entire stay in the hospital. The rickets was treated during this period with viosterol, 10 drops three times a day, and cod liver oil, 1 teaspoonful three times a day.

The 19 specimens of urine examined during the three weeks of hospitalization showed a persistent albuminuria, from a trace up to 2+ albumin. The specific gravity varied from 1.020 to 1.033, and sugar from a trace up to 1+ was present in a number of specimens. The microscopic examinations of the urinary sediment showed a few hyalin and granular casts, a varying number of pus cells from 5 to 20 per low power field, and 3 to 5 red blood cells per low power field. On April 26, 1930, the blood sugar was .09 per cent, and on May 5, 1930, it was .117 per cent.

On May 11, 1930, the 23rd day in the hospital, the infant weighed 8,200 grams. There was no fever and no edema during the period of observation. Because of the infant's failure to gain weight more rapidly, the parents decided to move the infant from the hospital against advice. She was sent home on a general diet with viosterol, 10 drops three times a day, and cod liver oil, 2 teaspoonfuls three times a day. The rickets had shown no clinical improvement while the infant was in the hospital. The diagnosis on leaving the hospital was chronic parenchymatous nephritis and severe rickets.

True renal rickets was suspected when correspondence with the parents revealed that the infant did not respond to the intensive antirachitic therapy and that her height and weight remained stationary. The parents were advised to bring the child to the hospital for complete metabolic studies. This was not done and the child was not seen again until 18 months later. During this interval, the patient's appetite remained poor and her weight and size remained unchanged in spite of the dietary measures and the intensive antirachitic therapy.

On September 12, 1931, at 4 A.M., the patient was admitted to Abbott Hospital in a moribund condition and died six hours later. The immediate cause of death was bronchopneumonia. On this admission, the patient's weight was 7,250 grams, approximately the weight of a six months infant; the body length was 77 cm., approximately the average length for a one year old child. She presented evidence of florid rickets; prominent bossae of the skull, open anterior fontanelle, marked enlargement of the epiphyses at the wrist joints; and a genu-vulgum deformity.

POSTMORTEM EXAMINATION

The body was that of a markedly undernourished and definitely undersized female child, 77 cm. long, and weighing 7.3 kgms. The skin had a noticeable light yellowish discoloration, but the conjunctivae showed no jaundice. There was no edema. The child showed evidence of marked rickets. The anterior fontanelle was open and measured 2.5 cm. in the transverse diameter. The frontal and parietal bosses of the skull were prominent. There was a marked beading of the ribs at the costechondral junctions and a noticeable flare of the lower ribs. The epiphyses of the wrists and the ankles were enlarged, and there was a definite genu valgum deformity.

The peritoneal cavity was essentially negative. The heart weighed 40 grams and showed no striking changes. The lungs each weighed 70 gms. and an extensive bronchopneumonia was found in both. The pancreas was normal. The liver and spleen showed evidence of acute congestion.

The kidneys, ureters, and bladder were removed together. The right kidney weighed 150 gms., the left 100 gms. They were both large and extremely pale. The capsule stripped with ease and the kidney surface appeared smooth. The cut surface showed a pale gray parenchyma with a yellowish color in the cortical zone. The cortex and medulla were well differentiated. There were no hemorrhages nor infarcts. The kidney, pelvis, and ureters were normal. The bladder contained about 15 c.c. urine clouded by postmortem desquamation of the epithelial cells. The thyroid and adrenal glands showed nothing remarkable.

The dissecting knife met with a decreased resistance cutting through the epiphyses of the lower ends of the femora. Grossly, there was a marked widening and an irregularity of the epiphyseal zone of the bone. A section of the lower end of the femur was removed for microscopic study. The permission for examination of the head and spinal cord was not given.

MICROSCOPIC EXAMINATION

The microscopic sections of the kidney were submitted to Dr. E. T. Bell of the Department of Pathology at the University of Minnesota. There was a marked dilation of the convoluted tubules with thinning of the epithelium. These tubules showed a moderate accumulation of fat. There were a number of glomeruli showing hyaline and atrophic changes, but this was within the limits seen in any normal kidney. The only evidence of renal degeneration was the distension and accumulation of fat in the convoluted tubules. The blood vessels appeared normal, and the interstitial tissue showed no changes. The appearance was that of a marked nephrosis with no signs of a renal insufficiency.

The sections of bone presented a high degree of disorganization in the zone of growth, with a definite widening of the epiphyseal zone. The outline of the cartilage was markedly irregular, in most places lacking the regular columns. The blood vessels of the bone marrow broke through the cartilage and osteoid tissue in a highly irregular way. There was a large amount of osteoid tissue breaking up the cartilage columns with no evidence of any tendency toward healing. The great thickness of the osteoid tissue suggested that this condition had been present for a long time. The structure was that of a marked case of

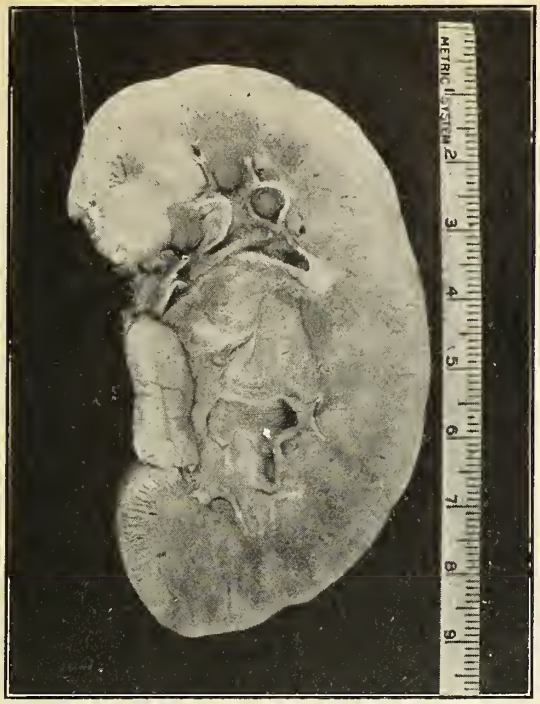


Figure 1. Gross specimen sectioned; size and weight of kidney comparable to adult kidney. Surface of kidney is pale and smooth; cortex and medulla well differentiated; no gross evidence of renal insufficiency.



Figure 2. Photomicrograph of section of lower femoral epiphysis; marked rickets. High degree of disorganization with definite widening of growth zone; irregular outline of cartilage; large amount of osteoid tissue breaking up the cartilage column with no signs of healing. Hematoxylin-eosin stain, magnification x 90.

rickets, with no signs of healing. Dr. Dallas Phemister and Dr. Bengt Hamilton, of the University of Chicago, reviewed the microscopic sections of bone, and concurred with our diagnosis.

The sections of lung showed an extensive bronchopneumonic process. There was a marked alveolar exudate containing polymorphonuclear leucocytes and some fibrin. Some alveoli were filled with red blood cells and serum. Between the areas of pneumonic consolidation, the alveoli appeared normal, and in some zones were atelectatic. Several of the bronchioles contained a purulent exudate.

The diagnosis was: (1) Bronchopneumonia; (2) Marked rickets without signs of healing; (3) Dwarfism; (4) nephrosis; (5) acute congestion of the liver and spleen.

COMMENT

The excellent article by Mitchell[6] gives a comprehensive discussion of renal rickets. It is of interest, in considering our case, to observe that the majority of cases reviewed in his article presented at postmortem examination the granular atrophic kidney or the final stage of chronic parenchymatous nephritis. As shown by Mitchell and others, the varied pathologic changes in the kidneys resulted in renal insufficiency. The changes in the bones and the retardation of body development were regarded as subsequent manifestations of a metabolic disturbance.

Clinically, our patient presented a picture similar in most respects to that of renal rickets. There were present severe rachitic changes uninfluenced by prolonged antirachitic therapy; so marked a retardation of growth as to merit the term, dwarfism; and evidence of a chronic kidney lesion. The absence of a renal insufficiency, however, distinguishes this case from renal rickets as described in the literature. While it is unfortunate that further determinations of the kidney function were not done, the autopsy examination of the kidneys gave good evidence as to their functional capacity. A study of the calcium balance was objected to by the parents of the patient.

At postmortem examination, the kidneys in our case were greatly enlarged, pale, and smooth. The right kidney weighed 150 grams, the left kidney 100 grams, or approximately three times as heavy as the kidneys of a normal child three years and two months of age. Microscopically, the sections of the kidneys showed a marked dilatation of the convoluted tubules with thinning of the epithelium. These tubules showed a moderate accumulation of fat. The glomeruli and the blood vessels appeared normal. The picture was that of a marked nephrosis with no signs of a renal insufficiency. Dr. E. T. Bell was of the opinion that the increased size and microscopic findings in the kidneys could not be entirely attributed to changes secondary to an infectious process. The gross and microscopic examinations of the bones showed marked rickets with a high degree of disorganization in the zone of growth. There were no signs

of healing or response to the intensive antirachitic treatment.

Mitchell's hypothesis[6], that the renal insufficiency in renal rickets interferes with the absorption of calcium because of inability to excrete phosphates, does not explain the marked rickets and dwarfism in our case. The presence of functioning kidneys in the patient described eliminated the renal factor as a probable cause of the metabolic changes present. Although a definite etiology cannot be established in our case, it would seem that the findings are probably results from some common endogenous factor.

SUMMARY

A case of rachitic dwarfism in a female child, three years and two months of age, with a marked nephrosis showing no signs of a renal insufficiency, is reported. The similarity to the syndrome known as renal rickets, is considered. It is suggested in our case that the marked rickets, dwarfism, and failure to respond to prolonged antirachitic therapy are probably all the results of some common endogenous factor.

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— OSMJ —

County Relief Diretcors have been instructed by the State Relief Commission to "give osteopathic physicians and surgeons who comply with the Ohio laws and the requirements of the State Relief Commission the same opportunities as other medical practitioners to practice their profession in relief cases when requested by the client". The announcement stated that "when osteopathic service is requested by the relief client, such service shall be authorized by the County Relief Director on an individual basis, if the osteopathic physician and surgeon concerned agrees to regulations issued by the State Relief Commission governing medical attention."

Official Death Rates For 1933 Announced by Census Bureau

The U. S. Bureau of the Census announces that in 1933 in the United States there were 1,342,073 deaths from all causes, representing a mortality rate of 10.7 per 1,000 estimated population. This is the lowest death rate since the annual collection of mortality statistics was begun in 1900. With the admission of Texas in 1933, the Bureau is now able, for the first time, to publish deaths and death rates complete for the entire population of continental United States.

Of the 18 groups of causes of death, 11 show decreases in rates as compared with the previous year; 5 show virtually no change, and only 1, "diseases of the circulatory system", shows a significant increase. The cause within this group which showed the greatest increase, both in the number of deaths and in the death rate, was "diseases of the coronary arteries". The 1932 rate for diseases of the digestive system (73.6) shows a slight increase over that for 1932 (72.7), but both rates are lower than that for 1931 (79.8).

The death rate from "cancers and other tumors" has steadily increased during the past 15 years. In 1933, as in 1929, this increase was halted temporarily when the rates were slightly lower than for the next preceding years, 1932 and 1928, respectively.

Of the decreases in death rates for 1933 those for the following groups are noteworthy: "Infectious and parasitic diseases", "diseases of the respiratory system", and "diseases of the genitourinary system". The decrease for the first of these groups is largely accounted for by the drop in the number of deaths from influenza and tuberculosis. In the second group the decrease is attributable mainly to the lower rates for the pneumonias. The decrease in rate for the third group is in keeping with the decline during the last few years in the death rate from "chronic nephritis". The decrease in "diseases of pregnancy, childbirth, and the puerperal state" was approximately the same from 1932 to 1933, as from 1931 to 1932, and is due in large measure to the lesser number of deaths from puerperal albuminuria and eclampsia, and puerperal septicemia.

Although the rate for "violent and accidental deaths" was slightly lower in 1933 than in 1932, it will be found that within this group the rates for some of the individual causes, notably "homicide" and "automobile accidents", are higher.

— OSMJ —

The Southeastern Surgical Congress, through its secretary, Dr. B. T. Beasley, Atlanta, announces the sixth annual assembly of the Congress which will be held in Jacksonville, Florida, March 11, 12 and 13.

FEDERAL INCOME TAX RETURNS MUST BE MADE BY MARCH 15; PROCEDURE FOR PHYSICIANS AND CHANGES IN LAW SUMMARIZED

BLANKS for making Federal income tax returns for the calendar year 1934 have been mailed to all taxpayers of record by the Collectors of Internal Revenue in Ohio.

These blanks, properly filled out, must be filed with the collector of the district in which the taxpayer resides on or before March 15, 1935.

Any physician required to make a return but who fails to receive an income tax blank should apply to the Collector of Internal Revenue for his district. A list of the four revenue districts of Ohio and the counties comprising each is appended to this article.

Returns for 1934 should be made in accordance with the provisions of the Revenue Act of 1934.

The new United States Congress, now in session, may make some changes in the Revenue Act of 1934, enacted in May, 1934. However, up to the time this issue of *The Journal* went to press, no legislation revising the income tax law had been enacted.

In case retroactive changes in the Act of 1934 are made by the present Congress, notices will be sent to all taxpayers by Collectors of Internal Revenue explaining such changes and summarizing new procedures. In event of any changes they will be analyzed in *The Journal* at a later date.

A number of important changes in the income tax law and procedure were made through enactment of the Revenue Act of 1934, which supersedes the Act of 1932.

ADDITIONS TO AND CHANGES IN LAW

Some of the important new provisions contained in the Act of 1934 and which should be followed in making returns on 1934 income follow:

(1). The 1934 Act provides for a single normal tax of 4 per cent on net income in excess of exemptions and credits, instead of 4 and 8 per cent as under the 1932 Act.

2). New and increased surtax rates are provided in the 1934 Act. The new surtax rates begin at 4 per cent on the first bracket—surtax net income of $4000 to $6000—and graduating to 59 per cent on brackets of over $1,000,000 of surtax net income. "Surtax net income" is defined as the amount of net income in excess of the personal exemption and the credit for dependents. The personal exemption and credit for dependents were not allowed under prior law for surtax purposes. No surtax is levied against surtax net incomes of $4000 or less.

(3). The 1934 Act revives the earned income credit. It permits a deduction from income subject to the normal tax of 4 per cent, of 10 per cent of the earned net income, but not in excess of 10 per cent of the amount of the net income. Income up to $3000 is presumed to be earned. The maximum amount that may be considered as earned income is $14,000 and proof is required to show that income over $3000 is earned. Earned income is considered income from personal efforts as distinguished from investments.

(4). Detailed provision is made in the 1934 Act regarding the listing of capital gains and losses for taxation. Stocks and bonds come under this provision. Stocks and bond losses up to $2000 are deductible but the excess losses over $2000 may be applied only against gains. In figuring gain or loss in the sale or exchange of a capital asset, the percentage of gain or loss is based upon the length of time the capital asset has been held.

(5). The deduction for contributions to organizations established and operated exclusively for religious, charitable, scientific, etc. purposes is limited by the addition of a clause, "and no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation".

(6). Losses from sales to a member of the family are not allowed; nor losses on sales between a corporation and a stockholder (except in cases of distribution in liquidation) where such stockholder, including his family, owns more than 50 per cent in value of the outstanding stock.

(7). The Act of 1934 permits as credit against net income for the purpose of the normal tax, interest on obligations of a corporation organized under Act of Congress if (a) such corporation is an instrumentality of the United States; and (b) such interest is included in gross income; and (c) under the act authorizing the issue thereof, such interest is exempt from normal tax.

(8). Estate, inheritance, legacy, succession and gift taxes are not deductible.

(9). The 1934 Act contains a new provision relative to income from annuities. Amounts received as an annuity under an annuity or endowment contract should be included in gross income; except that there shall be excluded from gross income the excess of the amount received in the taxable year over an amount equal to 3 per cent of the aggregate premiums or consideration paid for such annuity (whether or not paid during such year), until the aggregate amount excluded from gross income equals the aggregate premiums or consideration paid for such annuity. Interest paid or incurred to purchase or carry an annuity is deductible.

(10). Losses from wagering transactions are

deductible only to the extent of the gains from such transactions.

(11). A new section of the 1934 Act provides for a surtax on the "undistributed adjusted net income" of personal holding companies, in addition to the regular tax rates.

(12). Every person required to file an income return is required to make with such return a correct statement (Form 1094) of the following items shown on the return: (a) name and address, (b) total gross income, (c) total deductions, (d) net income, (e) total credit against net income for purposes of normal tax, (f) tax payable. Failure to file such a statement will cost the taxpayer $5.00 in addition to his income tax. Such statements are open to public inspection under certain conditions and regulations.

Provisions of the Act of 1934 relating to capital gains and losses, personal holding companies, and "in-the-family" transactions are lengthy and technical. Physicians having occasion to make use of these provisions should obtain expert advice in executing their return.

PROCEDURE FOR PHYSICIANS

Following is a detailed analysis of the procedure physicians should follow in filling out blanks for their 1934 income and an example of how computations should be made:

Every physician whose net income for 1934 was $1000 or more, if single, and $2500 or more, if married or the head of a family, must file an income tax return on or before March 15, 1935. He also must file a return if his gross income was $5000 or more, irrespective of marital status and net income.

All physicians and other professional men are required to use Form 1040 in submitting returns, regardless of the amount of net income.

All groups, joint ventures and other incorporated organizations must file returns as partnerships or corporations. Such return must list the names and addresses of the individuals who would be entitled to share in the net income if distributed and the amount of the distributive share of each individual. The members of such groups or corporations must report their distributive shares as their own income.

GROSS INCOME

Gross income includes gains, profits and income derived from professional services, business activities, salaries, wages, sales, dealings in, or exchange of real or personal property, rents or royalities, certain forms of dividends and interest, bonuses received as compensation, money collected on old accounts charged off in previous years as "bad debts", and funds received from all other sources.

PERSONAL EXEMPTIONS

If married and living with wife, or the head of a family, for the entire year, an exemption of $2500 is allowed; if single and not a head of a family, an exemption of $1000 is permitted, as credit against net income for the purposes of the normal tax and the surtax.

Credit of $400 is permitted for each dependent under 18 years of age or each physically or mentally handicapped dependent regardless of age. The credit is not allowed in the case of a dependent minor over 18 years of age even if such minor is attending school.

In case of a change during the calendar year of the status of the physician in so far as it affects the personal exemption or credit for dependents, the personal exemption and credit should be apportioned in accordance with the number of months and after such change. Authority for prescribing rules and regulations for such apportionment is given to the Commissioner of Internal Revenue.

A husband and wife living together shall receive but one personal exemption. The amount of such personal exemption is, as previously stated, $2500. If such husband and wife make separate returns, the personal exemption may be taken by either or divided between them.

ITEMS NOT REPORTABLE AS INCOME

The following items *should not* be included in gross income since they are *exempt* to Federal income tax:

Amounts received under a life insurance contract paid by reason of the death of the insured. If such amounts are left with the insurance company under an agreement to pay interest thereon, *the interest payments must be included* in gross income.

Amounts from annuity or endowment contracts received during the taxable year equal to the excess of the amount received over an amount equal to 3 per cent of the aggregate premiums or consideration paid for such annuity until the aggregate amount excluded from gross income equals the aggregate premiums or consideration paid for such annuity.

Cash or value of property acquired by gift, bequest or inheritance. Income from such property *is* taxable, however; and estate, inheritance and gift taxes are *not* deductible.

Damages received in personal actions and compensation from health and accident insurance.

Dividends on stock of Federal Reserve Banks, land banks, and intermediate credit banks; dividends from corporate earning accumulated prior to March 1, 1913; stock dividends and rights.

State jury court fees and state court receivership fees.

Interest upon the obligations of a state, territory, or any political subdivision thereof; interest from securities issued under the Farm Loan Act; interest on Liberty 3½ per cent bonds; interest on the obligations of the possessions of the United States; interest on U. S. Bonds and on obligations

of the United States issued prior to September 1, 1917, and on obligations of a corporation organized under Act of Congress, if such corporation is an instrumentality of the United States to the extent provided in the respective Acts authorizing the issue thereof as amended and supplemented; interest received on Liberty 4 per cent and 4½ per cent Bonds and certain other U. S. obligations if the total holdings are not in excess of $5000.

Compensation and allowances received under the provisions of Titles 2, 3 and 4 of the World War Veterans' Act of 1924; and pensions received from a state or the United States.

Interest received from U. S. Treasury Notes *is reportable* as income but is subject *only to surtax* since it is deductible as credit against gross income in computing net income.

DEDUCTIBLE ITEMS

In computing net income, the following items may be deducted by a physician from gross income:

Office Rental—If a physician pays rent to another person for office space, he may deduct such amount. If he owns his own home and maintains an office in it, he *cannot* claim deduction for office rent.

Automobile—The cost of repair and upkeep of an automobile used in professional visits may be deducted. That part of the salary paid to a chauffeur and attributable to time spent in driving his employer on profesisonal calls, may be deducted. Sums spent for taxi hire, car fare, etc., while on professional calls, may be deducted.

Loss on an automobile used in professional business through depreciation may be deducted. The depreciation which should be deducted annually is figured by dividing the cost price of the machine by the number of years of its usefulness. If a physician has one automobile which is used exclusively in professional business, he may deduct the full depreciation each year. If the machine is used only partly in professional business, the deductible depreciation should be computed on the basis of the amount of time the car is used for professional purposes. If a physician possesses two cars, each of which is used partly in professional business, the deductible depreciation on each car should be computed on the basis of the amount of time each car is used for professional purposes. In other words, if an automobile is used only partly for business purposes, depreciation may be deducted only on a proportionate part thereof, the amount of depreciation depending on the amount of time the machine is used in professional business.

Professional Dues—Dues paid to professional associations to which, in the interest of his profession, the physician belongs, may be deducted. Expenses incurred in taking graduate courses have been held *not* to be deductible.

Traveling Expenses—Traveling expenses necessarily incurred by a physician on professional calls and in attending medical conventions for a professional purpose are deductible from gross income.

Salaries and Wages—Deductions are permitted for the salaries or wages of nurses, laboratory workers, technicians, assistants, stenographers or other clerical workers in a physician's office so long as their duties are connected with professional work; also for wages paid maids, janitors, etc., for services rendered in connection with professional practice.

Medicines, Supplies, etc.—Cost of medicines used in the office to treat patients, medicine dispensed, bandages, laboratory materials, chemicals, and other supplies "consumed in the using" and necessary to operate the office may be deducted.

Equipment, Furniture, Library, etc.—Cost of surgical instruments and laboratory appliances of more or less permanent value may not be deducted but a percentage of the purchase price may be deducted annually under a depreciation account. The same rule applies to office furniture and books purchased for the physician's office library. If improvement to offset obsolescence and wear and tear or injury has been made and deduction for the cost claimed elsewhere in the return, claim should not be made for depreciation.

General Office Expenses—The cost of telephone, telegrams, heat, light, water, etc., used in professional service is deductible.

Debts—If the physician's books are kept according to the "Cash Receipts and Disbursement" system, he may not charge off any unpaid debt because he is then only reporting as gross income those accounts which have proved to be good. Bad accounts have not been reported and are therefore not deductible.

If books are kept on an "Accrual Basis" (where expense is actually incurred and payable even though not yet paid, or income earned although not yet collected), it is permissible to charge off all debts which have been definitely ascertained to be worthless during the fiscal year covered by the report.

The physician using this latter system must be careful to include in gross income bad debts which have been charged off in previous years but collected during the calendar year for which the return is filed.

Taxes and Licenses—All state taxes, except those assessed against local benefits of a kind tending to increase the value of the property assessed and those imposed upon the taxpayer upon his interest as shareholder of a corporation which are paid by the corporation without reimbursement from the taxpayer, are deductible.

All Federal taxes except income, war-profits and excess-profits taxes are deductible, including Federal excise taxes collected direct from the consumer or purchaser.

The Ohio gasoline tax has been held *not* deductible since it is imposed on the manufacturer.

All license fees which the physician is required to pay are deductible, including the narcotic tax, automobile license tag fee, local occupational taxes, taxes on club dues, etc.

Interest—Amounts paid out as interest upon indebtedness (except interest paid to carry nontaxable securities) are deductible.

Losses by Fire and Theft—Loss of and damage to a physician's equipment by fire, theft, or other cause, not compensable by insurance or otherwise recoverable, may be computed as a business expense, and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent to which it has not been made good by repair and the cost of the repair is claimed as a deduction.

Insurance Premiums—Premium paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries to a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment, and damage to or loss of professional equipment by fire or otherwise. Premiums paid on life insurance are not deductible.

Legal Expenses—Expenses incurred in the defense of a suit for alleged malpractice is deductible as business expense. However, expense incurred in the defense of a criminal action is *not* deductible.

Contributions, Gifts, etc.—It is permissible to deduct from gross income contributions made to charitable, religious, educational and scientific organizations, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation, to an aggregate amount not to exceed 15 per cent of the net income, exclusive of such contributions.

Supplemental Statement—Each physician should file with his income tax return, a correct statement of the following items shown on his return: Name and address; total gross income; total deductions; net income; total credits against net income for purposes of normal tax; tax payable. If such a statement is not filed, the Collector of Internal Revenue is authorized to prepare it from the return, adding $5.00 to the tax. These statements, or copies thereof, are available for public inspection under rules and regulations formulated by the income tax authorities.

NORMAL TAX RATE

As explained previously, the normal tax rate on 1934 income is 4 per cent on all net income in excess of exemptions and credits.

SURTAX RATES

In addition to the normal tax, a surtax is levied on surtax net income, that is, net income less the personal exemption and the credit for dependents, as follows:

Surtax net income of $4000, no surtax; $4000 to $6000, 4 per cent; $6000 to $8000, 5 per cent; $8000 to $10,000, 6 per cent; $10,000 to $12,000, 7 per cent; $12,000 to $14,000, 8 per cent; $14,000 to $16,000, 9 per cent; $16,000 to $18,000, 11 per cent; $18,000 to $20,000, 13 per cent; $20,000 to $22,000, 15 per cent; $22,000 to $26,000, 17 per cent; $26,000 to $32,000, 19 per cent; $32,000 to $38,000, 21 per cent; $38,000 to $44,000, 24 per cent; $44,000 to $50,000, 27 per cent; $50,000 to $56,000, 30 per cent; $56,000 to $62,000, 33 per cent; $62,000, to $68,000, 36 per cent; $68,000 to $74,000, 39 per cent; $74,000, to $80,000, 42 per cent; $80,000 to $90,000, 45 per cent; $90,000 to $100,000, 50 per cent; $100,000 to $150,000, 52 per cent; $150,000 to $200,000, 53 per cent; $200,000, to $300,000, 54 per cent; $300,000 to $400,000, 55 per cent; $400,000 to $500,000, 56 per cent; $500,000 to $750,000, 57 per cent; $750,000 to $1,000,000, 58 per cent; $1,000,000 or more, 59 per cent.

EARNED INCOME CREDIT

For purposes of the normal tax, an earned income credit is allowed by means of a deduction from net income of an amount equal to 10 per cent of the earned net income. If the taxpayer's net income is not more than $3,000, his entire net income is considered to be earned net income. If his net income is more than $3,000, his earned net income shall not be considered less than $3,000 but in no case shall the earned net income be considered more than $14,000.

HOW COMPUTATIONS ARE MADE

An example of how computations are made is given here for the information of physicians. The figures used in the following tabulations may appear out of proportion to the actual income of the average physician during 1934. However, they are used merely to illustrate how the normal and surtax rates should be applied.

If a married physician with no dependents and who rents his home and office had a gross income during 1934 of $15,000 and ordinary expenses, he should submit the following data on his return and compute his tax as follows:

Gross Income

Income from professional services		$12,000.00
Income from other sources:		
Rent from apartment	$1,500.00	
Taxable interest, dividends	1,500.00	
	$3,000.00	3,000.00
Gross Income		$15,000.00

Deductions

Depreciation of office furniture, etc.	$ 400.00	
Salaries and wages for office help	1,500.00	
Telephone, heat, light, etc.	400.00	
Automobile cost and depreciation	800.00	
Drugs, bandages, medicines, etc.	2,500.00	
Traveling expenses to medical meetings	300.00	
Office rent	800.00	
Dues, insurance	200.00	
Miscellaneous expense	100.00	
Business expenses	$7,000.00	
Taxes on apartment	500.00	
Interest on mortgage, overhead, etc.	300.00	
Total deductible expenses		$ 7,800.00
Net income (gross income, less deductible expenses)		$ 7,200.00

Computations

Surtax net income (net income less personal exemption $7,200.00 less $2,500.00)	$4,700.00
Earned net income (earned income less business expenses, $12,000.00 less $7,000.00)	$5,000.00
Earned income credit (10% of earned net income, $5,000.00)	$ 500.00
Income subject to normal tax (net income less personal exemptions and earned income credit; $7,200.00 less $2,500.00 and $500.00)	$4,200.00
Normal tax (4% of $4,200.00)	$ 168.00
Income subject to surtax (surtax net income in excess of $4,000.00)	$ 700.00
Surtax (4% of $700.00)	$ 28.00
Total tax (normal tax plus surtax)	$ 196.00

DISTRICTS AND COLLECTORS

Any physician failing to receive an income tax blank should apply to the Collector of Internal Revenue for his district. These districts, together with the name and address of the Collector, and counties comprising such districts follow:

For the Columbus District (Ohio 11th) Collector of Internal Revenue Harry F. Busey, Federal Building, Water and Gay Sts., Columbus, Ohio; comprising the following counties:

Adams, Athens, Coshocton, Delaware, Fairfield, Franklin, Gallia, Guernsey, Hocking, Jackson, Knox, Lawrence, Licking, Madison, Marion, Meigs, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Ross, Scioto, Union, Vinton and Washington.

For the Cleveland District (Ohio 18th) Collector of Internal Revenue Carl E. Moore, 262 Federal Building, Cleveland, Ohio; comprising the following counties:

Ashland, Ashtabula, Belmont, Carroll, Columbiana, Cuyahoga, Geauga, Harrison, Holmes, Jefferson, Lake, Lorain, Mahoning, Medina, Monroe, Portage, Richland, Stark, Summit, Trumbull, Tuscarawas and Wayne.

For the Cincinnati District (Ohio 1st) Collector of Internal Revenue Thomas J. Connor, Custom Building, Cincinnati, Ohio; comprising the following counties:

Brown, Butler, Clarke, Clermont, Clinton, Fayette, Greene, Hamilton, Highland, Miami, Montgomery, Preble and Warren.

For the Toledo District (Ohio 10th) Collector of Internal Revenue Charles H. Graves, Toledo, Ohio; comprising the following counties:

Allen, Auglaize, Champaign, Crawford, Darke, Defiance, Erie, Fulton, Hancock, Hardin, Henry, Huron, Logan, Lucas, Mercer, Ottawa, Paulding, Putnam, Sandusky, Seneca, Shelby, Van Wert, Williams, Wood and Wyandot.

State Personal Property Tax Returns Due Between February 1 and March 31

Returns under the Ohio Personal Property Tax Law must be made between February 15 and March 31 annually.

All tangible and intangible personal property (not real property) in possession of a physician on January 1, 1935, which is subject to taxation under the Ohio law, should be listed on the return which should be filed with the county auditor between those dates.

Such returns should be made in duplicate. The so-called intangible tax statutes are intricate and complicated so each physician having taxable personal property for listing should obtain competent advice in case of doubt as to the meaning of any of the provisions of the law.

One of the complicated provisions of the tax law is that involving the listing of credits which are taxable at 3 mills on the dollar and which involves the computation of accounts receivable.

As defined in Section 5327 of the law, credits "means the excess of the sum of all current accounts receivable and prepaid items used in business when added together estimating every such account and item at its true value in money, over and above the sum of current accounts payable of the business, other than taxes and assessments".

The same section states that "current accounts includes items receivable or payable on demand or within one year from the date of inception, however evidenced".

As the first step in making his return under the section relating to credits, a physician should estimate by his best judgment the ACTUAL VALUE of his current accounts receivable—the amount that can probably be collected.

In listing his current accounts receivable, the physician should note after each account what he considers the value of the account. If he believes the account can be collected in full, it should be listed at its full face value. Otherwise, it should be listed at 75%, 50%, 25%, 10%, etc., of its full

face value, or of "no value" in case that is considered the "actual value" of the account. The total of these estimates is the total to be entered as "current accounts receivable" and used in computing credits.

This procedure permits the physician to charge off bad debts since in his 1935 return he would be permitted to return as of "no value" accounts receivable which he listed in 1934 but no part of which was collected during the past year. Moreover, it permits a physician to depreciate the actual value of accounts returned in 1934 but which have decreased in actual value during the past year.

PHYSICIANS, MEDICAL SERVICE, MEDICINES AND THE NEW OHIO SALES TAX LAW

BULLETIN

Just as *The Journal* went to press, The State Tax Commission issued definite interpretations holding physicians are "consumers" rather than "sellers" under the sales tax law, in line with the three points emphasized by black margin rule in this article.

UNDER the Ohio Sales Tax statute, a physician is not construed to be a "vendor" or "tax collector" in the general practice of his profession where medicines or appliances are dispensed as an incident to his professional service and for which no separate charge is made in addition to his professional fee.

General exemptions to which the sales tax does not apply are the following: "Casual and isolated sales by a vendor who is not engaged in the business of selling tangible personal property" or "to professional or personal service transactions which involve sales as inconsequential elements for which no separate charges are made".

Under the sections above quoted when services are rendered by a physician for a professional fee and when no separate charge is made for medicine, material, appliances, etc., furnished by the physician as an incidental part of his professional service no tax is to be collected by the physician.

In view of the fact that the sales tax is of *general* application to practically every tangible article and commodity, a sales tax must be collected some place along the line as a matter of routine. In fact, about the only things exempted from the Ohio Retail Sales Tax Law are those articles which are already taxed under special higher-rate statutes, such as gasoline, cigarettes and liquor. The only foods on which a tax is not assessed are fluid milk for consumption off the premises of the vendor, and bread in loaf form.

Under the general and broad terms of the law, physicians are required to pay a tax on drugs, bandages, appliances and instruments when purchased, but representatives of the State Medical Association pointed out to the State Tax Commission that under the terms of the law and the exemptions for professional services, it was not contemplated that physicians be classed as retail vendors nor required to pay a vendor's license fee or to collect taxes on the tangible things disposed of by them to their patients as an incidental part of professional practice.

Regulations issued by the State Tax Commission provide that where a physician is engaged in selling articles of tangible personal property to the public (whether medicines or other commodities) "not directly in connection with his examination or professional service" he is a "vendor" within the meaning of the Sales Tax Act, must procure a vendor's license, and collect a tax on all sales to such "customers" (as distinguished from "patients") in the manner prescribed under the law for those defined as being in "the business of selling tangible personal property at retail".

A group of druggists have contended to the State Tax Commission that since the sales tax applies to drugs sold by a druggist, even on a physician's prescription, and in the compounding of which pharmaceutical professional service enters as a large part of the cost, that physicians' fees, or at least that part which includes the dispensing of medicines and the use of bandages, appliances, etc., should be subject to the sales tax and physicians required to collect taxes from their patients.

To the contention of that group of druggists, representatives of medical organization presented strenuous objections to the Tax Commission.

The Tax Commission, taking into account the intention of the Legislature, properly ruled that physicians are "consumers" under the terms of the act, rather than vendors, and that they are not intended to be tax collectors. This ruling also properly permits scientific practice of medicine as a profession rather than as a business and permits dispensing—as contrasted with selling—of necessary medicines incidental to the professional service rendered to patients.

To summarize in general terms, the Tax Commission's interpretation means:

1. That the sales tax law does not contemplate the inclusion of professions or professional service under the broad definition of "the business of selling tangible personal property at retail".

2. That under the exemptions secured in the law, physicians may dispense drugs and other appliances to their patients without collecting a sales tax where no separate charge is made by the physician to his patient for such tangible articles.

3. That in view of the fact that the sales tax, under the broad terms of the law, must be collected somewhere along the line, physicians should be classed as "consumers" rather than as "sellers" and, therefore, they would be required to pay the sales tax on their medicines, equipment and appliances when they are purchased from the druggist, jobber or other source.

Some physicians have contended that as they do not "consume" the medicine purchased by them, that they should not be classed as "consumers". On the other hand, if physicians are not classed as consumers, they would have to be classed as "retailers" and, therefore, would become tax collectors and required to keep records, collect taxes from their patients, render receipts and make an accounting and a return of the taxes to the proper taxing authorities.

Under the terms of the law, the word "'consumer' means the person to whom the transfer effected or license given by a sale is or is to be made or given".

Questions have arisen in connection with the dispensing of glasses by physicians. A ruling of the Tax Commission holds that glasses manufactured by an optician and sold to a customer, even on a physician's prescription, are subject to the sales tax, and that the tax must be collected from the purchaser.

In the event charges for professional services or examinations by oculists, which are rendered apart from the making of eye glasses, are itemized separately, the tax will not be computed or collected on "the professional service", but must be collected on the sale of the glasses.

Therefore, the ruling means that where a physician dispenses glasses and makes a separate charge for such glasses in addition to his professional fee for the examination of eyes, that a tax must be collected on the sale of such glasses, and that such physician in that instance and to that extent, be classed as a "retailer" and required to take out a retailer's license at the rate of $1.00 per year. Such licenses are procurable through the offices of the county treasurers and licensed vendors of tax coupons.

Accurate Residence Data on Birth, Death Certificates Sought

An effort to enhance the value of vital statistics through bringing about the proper allocation of all births and deaths to the place of residence has been undertaken by the Division of Vital Statistics, State Department of Health, in cooperation with the U. S. Bureau of the Census.

The success of the plan will depend on the cooperation of physicians and others in seeing that each death certificate designates the residence of the deceased and each birth certificate the residence of the mother.

With this data available, the U. S. Bureau of the Census will be able to allocate each certificate to the proper state. In addition, it will supply state registrars with data which will be helpful in properly allocating births and deaths to the county or city of residence.

Under date of January 16, the following letter explaining the new plan and asking cooperation was sent by I. C. Plummer, chief of the Division of Vital Statistics, State Department of Health, to Ohio physicians:

"To All Physicians:

"In cooperation with the United States Bureau of the Census, the Ohio Department of Health will undertake to allocate births and deaths to the place of residence. DEATHS TO RESIDENCE OF DECEASED AND BIRTHS TO RESIDENCE OF MOTHER.

"This does not mean any change on the certificate of birth and death but closer attention given to residence, in order to make the work we have been carrying on more complete.

"By allocating births to the residence, it is hoped the present record will be of much greater value than heretofore. All certificates will be filed in the district in which the birth or death occurred but for other purposes allocated to the place of residence.

"The residence is defined as 'usual place of abode' and should be written upon the record even though the mailing address is the same as the place of birth or the district in which the birth occurred. When a birth ocurs in a hospital the certificate should always contain the mailing address of the mother as well as the name of the hospital or institution.

"This is the most progressive step that has been taken in the preparation of vital statistics in a generation. This department and the United States Bureau of the Census urge your cooperation in accuracy and promptness in registration."

— OSMJ —

Charles W. Mixer, self-styled cancer specialist of Hastings, Mich., is dead of cancer on the eve of his prosecution on charges of violating the Federal Food and Drugs Act. His principal medicine, "Mixer's Cancer and Scrofula Syrup", composed of potassium iodide, senna, licorice, yellow dock root, sarsaparilla, wintergreen, glycerine, alcohol and sugar syrup, had for a long time evaded the Federal law, until food and drug inspectors intercepted a shipment to Chicago and based the recent case on it.

SOCIAL SECURITY AND NEW FEDERAL RELIEF PROGRAMS BEFORE CONGRESS; HEALTH INSURANCE PLAN IN THE MAKING

PROPOSED legislation to inaugurate a "broad program of social security" and a new national relief set-up has held the spotlight during the present session of the 74th Congress, which began January 1.

Being vitally interested in these questions, Ohio physicians doubtless have followed the Washington merry-go-round with more than customary interest.

Nevertheless, a brief recapitulation of events and developments so far in Washington, as well as in Columbus where the Ohio General Assembly is convening, is in order, if for no other reason than to re-emphasize the necessity for preparation and concerted action on the part of organized medicine.

When this was written it was impossible to state definitely what so-called social legislation will be enacted or just how the proposed new federal relief program will operate.

However, preliminary events indicate there will be considerable experimentation in both fields during ensuing months.

* * *

ON January 17, President Roosevelt presented to Congress his long-heralded social security program, the initial cost of which was estimated at $100,000,000. Legislation incorporating the recommendations was introduced on the same day by Senator Wagner of New York.

The President's program, based largely on a voluminous report prepared by his Committee on Economic Security (reference to which has been made frequently in *The Journal*), included the following recommendations:

1. A system of unemployment compensation.
2. Old age benefits, compulsory and voluntary.
3. Federal grants-in-aid of state mothers' pension systems and for the protection of homeless, neglected, dependent and crippled children.
4. Federal aid for maternal and child health activities and enlargement and extension of the activities of public health departments.

The program calls for cooperation between the Federal Government and the various states. Monetary contributions by both the Federal Government and the states, raised through payroll taxes and contributions by both employers and employes, with initial outlays by the Federal Government to inaugurate the systems, are recommended for the old age and unemployment programs.

The President told Congress that he was not prepared to urge adoption of health insurance, adding: "Groups representing the medical profession are cooperating with the Federal Government in the further study of the subject and definite progress is being made."

There are strong indications, however, that proposals for some kind of health insurance will be projected into the social security picture in the near future.

Evidence of this is found in that section of the report of the President's Committee on Economic Security pertaining to public health, which said in part:

"As a *first* measure for meeting the very serious problems of sickness in families with low income, we recommend a nation-wide preventive public health program. The program contemplates (1) grants-in-aid to be allocated through state departments of health programs from state and local resources; (2) direct aid to states in the development of state health services and the training of personnel for state and local health work; (3) additional personnel in the United States Public Health Service to investigate health problems of interstate or national concern.

"The second major step we believe to be the application of the principles of insurance to this problem. We are not prepared at this time to make recommendations for a system of health insurance.

"We have enlisted the cooperation of advisory groups representing the medical and dental professions and hospital management in the development of a plan for health insurance which will be beneficial alike to the public and the professions concerned.

"We have asked these groups to complete their work by March 1, 1935, and expect to make a further report on this subject at that time or shortly thereafter."

From other sources there is evidence health insurance, doubtless, will be added to the security program.

To quote from a United Press dispatch: "He (President Roosevelt) will submit a *health insurance proposal* around March 1 *** Possibly

health insurance will be financed through general tax contributions."

There also is the possibility of an effort to tack onto the President's program the health insurance measure, sponsored by Senator Black of Alabama and drafted by the American Association for Social Security.

All of which leaves the medical profession pretty much up in the air as to what to expect and what is being planned in inner circles.

But, the profession can and should keep in touch with the Ohio members of Congress—and the State Legislature to which various kinds of social insurance proposals also will be submitted—as frequently as possible; supply them with accurate information; and present to them the concerted medical viewpoint on various questions. In the final analysis, Congress and the State Legislature will have the last word.

* * *

MORE or less radical changes in methods of caring for the millions of unemployed and needy may be anticipated.

"The Federal Government must and shall quit this business of relief," President Roosevelt told Congress and he proposed a new national relief program, incorporating some of the features of the one which has been in operation for almost two years and a number of new ideas and policies.

In brief, the President's suggested relief program is as follows:

Require local communities to assume a greater share of the relief burden; make local official and voluntary relief agencies responsible for the care of many unemployables and those unable to maintain themselves independently even in ordinary times; concentrate all emergency relief activities, including emergency public works, in a single, enlarged Federal plan and under one agency; establish the following principles to govern this new program designed to provide millions of unemployed with emergency public employment: (1) all work undertaken shall be useful, afford permanent improvement or create future wealth, (2) compensation on emergency public works shall be larger than the amount now received through direct relief but not so large as to encourage the rejection of opportunities for private employment; (3) projects should be undertaken on which a large percentage of direct labor can be used, (4) preference should be given to projects which will be self-liquidating, (5) there should be as little competition as possible with private enterprise, (6) projects should be planned so they can be tapered off in ratio to the pick-up of private industry, (7) effort should be made to locate projects where they will serve the greatest unemployment needs.

The President has taken the position that the responsibilities for relief must be returned as rapidly as possible and expedient to local communities. In his budget message, he requested four billion dollars in a lump sum be appropriated to carry out the relief program he has suggested.

How many local communities, already on the verge of bankruptcy, are going to meet the burden of caring for those who will be taken from Federal relief rolls and turned over to local authorities, is a serious question that so far remains unanswered.

There are reports that the present Federal Emergency Relief Administration is to be abolished and that a new and enlarged Federal agency will be created to handle not only the proposed new relief program but administer the various social insurance plans the Federal Government will create.

* * *

WILLIAM A. WALLS, executive head of the Ohio Relief Commission, says Ohio will be ready to carry out the new features of the new Federal relief program when put into operation.

No mention has been made either by Federal or state spokesmen of any plans to improve or work out a more efficient and equitable plan for providing medical care and hospitalization for those on the relief rolls.

Incidentally, the Ohio Relief Commission has issued a ruling that osteopathic physicians and surgeons who comply with the Ohio laws and requirements of the State Relief Commission may treat relief patients in accordance with the provisions of the General Code governing their licenses.

Anticipating that eventually a large proportion of poor relief work will be returned to local communities, the Ohio Commission on County Government in its report to the Governor, recommends that counties consolidate all local relief activities in a newly-created County Welfare Department.

Mr. Walls, the new head of the state relief department, is a close personal friend of Governor Davey and former superintendent of schools of Kent. He succeeds Frank D. Henderson, former adjutant general and director of relief activities in Ohio since the creation of the State Relief Commission.

* * *

WINTHROP W. ALDRICH, New York banker and head of the New York State Charities Aid Association, in a public statement has suggested the establishment in each community of a "new instrumentality which is made up neither of politicians nor social workers, which will study the relief situation, follow its development daily and see to it that relief is adequate, and economically administered". He believes a voluntary board, similar to the draft boards of World War vintage, to act in an advisory and supervisory capacity to local relief

administrations, should be authorized in each locality.

Ohio physicians will recall that for a year and a half efforts have been made, without success, to have the Ohio Relief Commission authorize the formulation of boards of this kind to assist county relief directors on health and medical activities.

An advisory board to the relief administration of one large Ohio county resigned recently, stating there is no excuse for its existence since it has never been consulted and its suggestions ignored.

* * *

TO top off the present whirligig, there are the activities of the Townsend old age pension advocates, the disciples of Sinclair and "EPIC", the followers of Huey Long and his redistribution of wealth scheme and scattered groups, fostering "sure-shot remedies" for the social and economic ills of mankind generally and flooding the country with propaganda concerning their weird and fantastic proposals.

All in all, Washington—and the nation—is witnessing one of the strangest and most bewildering spectacles in all history.

Where are we going?

—OSMJ—

Professional Employes Receive Wage Classification Under Retail Trade Code

Professional persons in the retail trade working unlimited hours are entitled to the same minimum wage classifications as executives working beyond code hours under an amendment to Article V, Section 4 (a) of the retail code, approved by the National Industrial Recovery Board, it has been announced. It was estimated that possibly 100,000 persons may be affected by the amendment.

Article V, Section 4 (c) of the code provides that executives who work unlimited hours must receive minimum wages ranging from $25 to $35 a week, according to population of the communities in which a retail establishment is located.

The term "professional person" is defined in the code. It includes, but without limitation, such employes as doctors, dentists, nurses, architects, training directors, artists, research technicians, statisticians, mechanical engineers, etc.

The retail trade code covers such groups as department and dry goods stores, harware, furniture, and shoe stores, mail order houses, booksellers, limited price variety, music and men's clothing stores.

—OSMJ—

Dr. Erwin E. Nelson, of the University of Michigan, has been appointed principal pharmacologist in charge of the Drug Division of the Food and Drug Administration, according to an announcement by W. G. Campbell, Chief.

Medical and Surgical Licenses Granted to 31 by State Board at Its Meeting January 8

Thirty-one medical school graduates were granted licenses to practice medicine and surgery in Ohio by the State Medical Board at its meeting on January 8 in Columbus.

The board also granted certificates of practice to 10 osteopaths, 7 chiropractors, 9 mechanotherapists, 2 electro-therapists, 1 cosmetic-therapist and 8 masseurs.

Officers for the ensuing year were elected by the board as follows: President, Dr. J. G. Blower, Akron; vice president, Dr. J. R. Shoemaker, Cuyahoga Falls; treasurer, Dr. L. T. Franklin, Chillicothe; secretary, Dr. H. M. Platter, Columbus. Professor S. E. Rasor and Miss Clara Brouse were appointed entrance examiner and chief nurse examiner, respectively.

At the conclusion of the meeting, the board went to Cincinnati where it inspected the Eclectic Medical College which is completing its fourth year since its reorganization and is asking recognition of its graduates by the board. A report of the inspection will be discussed by the board at its next meeting, April 2.

Those granted medical and surgical examinations following examination were:

Joe B. Stocklen, Warrensville, Western Reserve University; Lloyd E. Drossel, Cleveland, Boston University; James H. Buskirk, Cincinnati, Georgetown University; John O. Neese, Springfield, Georgetown University; Morton E. Block, Dayton, New York Homeopathic Medical College; Edwin W. Cauffield, Akron, Hahnemann Medical College; John J. Coletta, Cleveland, Hahnemann Medical College; Hugh W. Eikenberry, Cleveland, Hahnemann Medical College; Stanley T. Garber, Cincinnati, Harvard Medical School; Franklin F. Dye, Reinersville, Jefferson Medical College; Howard M. Hebble, Springfield, Jefferson Medical College; Gordon H. Pumphrey, Mt. Vernon, Jefferson Medical College; James A. Gibney, Youngstown, Loyola University; Bela Klein, Cincinnati, Breslau University, Germany; Leon L. LaMonica, Akron, New York Homeopathic Medical College; Max M. Pomerantz, Cleveland, New York Homeopathic Medical College; Jacob G. Constantine, Cleveland, Laval University, Canada; Geza Komaromy, Cleveland, University of Budapest, Hungary; Elsie K. Snell, Cleveland, New York Homeopathic Medical College; Clarence M. Witzberger, Akron, New York Homeopathic Medical College; Walter W. King, Marion, Northwestern University; Harry Strauss, Cleveland, University of Toronto, Canada; Ralph R. Kerchner, Tiffin, Northwestern University; Charles A. Bogue, Warren, Temple University Medical School; Vera R. Drimer, Dayton, Medical College of Cluj, Romania; James A. Ellery, Shelby, Temple University; George S. Peters, Cleveland, Temple University; Hans Seidemann, Cleveland, University of Breslau, Germany; Robert W. Pollock, Cincinnati, University of Rochester; Hendrik M. Rozendaal, Mansfield, University of Leiden, Holland; Julian F. Baldor, Cleveland, University of Havana, Cuba.

CATECHISM ON SICKNESS INSURANCE

Pertinent Questions Likely to be Asked Physicians Regarding Proposals to Establish New System of Medical Service Answered in Brochure Issued by A. M. A. Bureau of Medical Economics.

DUE to the large amount of publicity in the press, over the radio, and elsewhere, concerning the activities of the National Committee on Economic Security, considerable public interest is being manifest in the economic and social aspects of sickness and medical service.

During the ensuing months, many physicians doubtless will be questioned frequently by their patients and other members of the laity regarding various methods of sickness insurance being promoted by certain groups who believe this is the only solution for some of the problems incidental to sickness and disability.

With increasing frequency, members of the medical profession undoubtedly will be asked to address lay groups and organizations on this and other social and economic questions relating to illness and medical service.

Therefore, it is important that all members of the medical profession be well-informed on such questions, especially as to the concerted medical viewpoint toward them, and be able to explain convincingly the objections and dangers in many schemes now under consideration for changing the present system of medical service.

Recently, the Bureau of Medical Economics of the American Medical Association formulated a "Sickness Insurance Catechism", consisting of a number of pertinent questions and answers regarding sickness insurance.

These questions and answers deal with many of the important aspects of sickness insurance. They are concise and to the point. After familiarizing himself with them, each physician should be able to discuss some of the medical viewpoints regarding sickness insurance.

Believing this material by the A.M.A. Bureau of Medical Economics will be helpful and valuable to every member of medical organization, the major points discussed are published in part by *The Journal:*

1. What is sickness insurance?

Sickness insurance is proposed as a method of distributing the economic burden of sickness. The first purpose was to distribute the burden of unemployment due to sickness. This is still the controlling motive in most of the systems and absorbs the larger part of their resources and determines their organization and administration. Medical service in the beginning was looked on primarily as a means of reducing the burden of cash paymetns during sickness. This pattern still dominates, although the medical service is now urged as the principal objective. The administrative machinery is still designed to collect, manage and distribute cash. It is in no way suited to administer a medical service.

2. How does insurance affect the medical service?

Medical service, unlike cash or material commodities, cannot be collected, stored and distributed without changing its qualities. Its value depends on the relations between the producer (the physician) and the consumer (the patient). Its distribution is a part of the service. The introduction of a third party who is neither physician nor patient is equivalent to adulteration of the service.

3. How does sickness insurance affect diagnosis?

Since insurance administration is controlled by cash considerations, quantity, rather than quality, of medical service is stressed. The essentials of a good diagnosis are time, patience, careful attention to details and sympathetic relations between a skilled practitioner and a cooperating patient. Insurance compels haste and tends to create antagonism between patient and physician. By removal of the essentials mentioned, insurance delivers little more than the dregs of a real diagnosis. The effort to substitute for these essentials something that will fit the cash standards of insurance causes exaggerated importance to be given to mathematical and mechanical analyses, pictures and measurements. But these are only one set of valuable, but often isolated, facts that must be integrated with the personal interview, history and individual examination through the knowledge and experience of the physician. Insurance tends to restrict this most vital part of the diagnosis.

4. How does insurance affect treatment?

Insurance almost inevitably leads to overmedication. It has become well-nigh proverbial that the diagnosis and treatment provided in insurance systems consists of a "look and a bottle." Insurance seeks to check the steadily rising cost

of drugs by the application of cash standards through restrictions on prescribing. Since sick individuals and scientific medical service do not fit these standards, treatment is hampered while the evil of unnecessary medication remains.

5. Do the best physicians enter insurance practice?

The Germans have a saying that "insurance service is always second class." While there are many individual exceptions, few would deny that in countries which have sickness insurance the medical level of ability is lower among insurance than private practitioners. Although the British Medical Association favors insurance, and the conditions of practice are less unsatisfactory than in almost all other systems, only about half of the licensed practitioners have expressed a willingness to enroll under the insurance regulations.

6. Does insurance decrease the amount of sickness among the insured?

Few achievements of the modern scientific age are more striking than the conquest of once widespread diseases in the progress of medical discovery. A host of diseases like smallpox, yellow fever, malaria and typhoid fever, which were once among the largest causes of sickness and death, have been abolished or reduced to a fraction of their former importance. In many others, improved methods of treatment have shortened the period of recovery. While morbidity statistics are inadequate in the United States, such evidence as is available indicates a decline in the amount of serious sickness from a number of causes. Although most of the advances in medicine, together with the improvements in sanitation and public health measures that are characteristic of modern civilization, are found in countries having sickness insurance, yet among the insured under practically every system the records show a constant increase of morbidity. This increase is not entirely due to the demand for "certificates of incapacity to work," required to secure cash benefits. This constitutes such a large and growing evil that in nearly every country having a sickness insurance system there is developing a strong and increasing movement for a complete separation of cash and service benefits. The increase in sickness among the insured is due to a deep inherent evil in insurance. Various studies of fairly large numbers of patients have led to the conclusion that from 40 to 75 per cent of all illnesses are complicated by mental disturbances. Insurance methods of treatment make almost impossible the patience, time, careful investigation and lengthy care with close personal relations that such patients require. Moreover, as studies of many systems have shown, insurance actually arouses conflicts, anxieties and desires that aggravate existing illnesses and create a host of new ones which cannot be treated properly by the methods that prevail under insurance. Prepayment for medical care, especially over a long period, creates a desire to "get something back" in the form of such care. This desire to "get something back" has a tendency to create the sickness that is the condition of obtaining the coveted service. This is not malingering nor even quite the same as the "traumatic neuroses" that cause so much trouble in workmen's compensation practice. In the latter cases there is at least a real or imagined injury as a beginning. But the cases under insurance are originated by insurance. Every sickness insurance system furnishes ample illustrations of these harmful developments. Physicians practicing in the German system estimate that from 30 to 50 per cent of the cases treated are created or aggravated by this situation. Fifty years of this system in the period of greatest medical progress in the war on disease has almost trebled recorded "morbidity" among the German insured.

7. Does insurance increase the practice of preventive medicine?

Even the most enthusiastic advocates of insurance admit that sickness insurance has done little to develop or encourage measures for the prevention of disease. Individual immunization, regular health examinations and measures for the detection and treatment of incipient disease are, in all insurance countries, largely dependent on other agencies than insurance. The insurance practitioner is too hurried and is held too closely by restrictions imposed by administrators to give much attention to preventive work. Such preventive work is more extensive, reaches a larger percentage of the population and is better supported by the general public and the medical profession in the United States than in countries having compulsory sickness insurance.

8. Does sickness insurance, by furnishing unlimited free medical service, encourage the detection and treatment of incipient disease?

It is highly probable that even the superficial examinations encouraged by insurance methods detect some such diseases that might not otherwise have been brought to medical attention. There are many physicians practicing under insurance whose professional integrity and scientific ability enable them to overcome the conditions encouraged by insurance and to select for thorough diagnosis those threatened by serious disease. It is somewhat significant that none of the often overenthusiastic propagandists of insurance have ever collected any facts to demonstrate whether cancer or tuberculosis, for example, are more frequently detected at an early stage among the insured than among the noninsured. On the other hand, many physicians with experience under insurance declare that the flood of patients with imaginary or

trivial complaints, or who come only to prove they are sick in order to draw cash relief or to "get something back" from their contributions, that crowd the office of an insurance physician not only compel a tendency toward hasty or superficial diagnosis but lead to suspicion of the actuality of symptoms described by the patient, and a disbelief in the existence of serious disease. The whole economic organization of insurance encourages attitudes and conditions hostile to a thorough detection of incipient disease.

9. Does sickness insurance lower the death rate?

The progress of medical science has been marked in every modern nation by a more rapid decline in mortality during the last half century than in any of the preceding centuries. The application of the triumphs of surgery, epidemiology, immunization and the advances in diagnosis and treatment in a multitude of directions has added a score of years to the average life. Where these advances in medical science have been utilized in public health work and private practice it is possible to demonstrate statistically their effect in reducing the death rate. But the advocates of insurance have not been able to show a similar statistical connection between the introduction or extension of insurance and a decline in the death rate.

10. Does sickness insurance reduce the cost of medical care?

Before this question can be answered properly it is necessary to have some comparative standards of medical care. These do not exist. It is certain that the first effect of insurance is to divert a considerable share of the contributions for medical care to costs of administration. In Germany (almost the only country where such statistics are available) there are more sickness insurance administrators than physicians in the scheme. The physician must spend a considerable portion of his time as a routine clerical worker filling out the numerous blanks and reports required. Not only is this a wasteful use of professional skill but it still further reduces the already scanty time available for medical service and prevents the continuous study essential to *good* medical service. While no comparative statistics are available, and probably would be impossible to gather, all obtainable information seems to lead to the conclusion that, considering all national differences, no less sums are spent for medical care for the insured than are spent by the uninsured, with the same economic resources.

11. How are physicians chosen for insurance practice?

There are wide differences in the various systems. In some there are so many restrictions and conditions that the physician is practically selected by the administrators. Where this is true and insurance is compulsory for a large portion of the population, it amounts to a secondary system of licensure, the conditions of which are acceptance of rules and regulations often established for reasons other than the furtherance of good medical practice. In the French, English and Scandinavian systems any licensed physician may enter insurance practice by simply agreeing to meet the conditions set up by the law.

12. How do the indigent receive medical care under sickness insurance?

Insurance leaves almost untouched the entire problem of care for the indigent sick who are not eligible to the benefits of sickness insurance systems. In no country has it perceptibly decreased expenditures for this purpose.

13. What has been the effect of insurance on the medical profession?

Economically its first effect in many countries was to increase somewhat the incomes of physicians whose practice was largely confined to the low income classes. Many patients who had hitherto paid nothing for medical care now had something paid for them through insurance. Later, in most systems, the income of physicians in insurance practice was reduced and at the same time the field for private practice had become so contracted that the total average of income was lower. Almost any system would have improved the conditions of English physicians where "medical clubs" prevailed. The members of these clubs paid a few cents weekly or monthly for which physicians agreed to give a sort of medical care. One of the arguments for insurance was that it would abolish the abuses of the "clubs," but these are now running on a large scale in spite of insurance, and bringing nearly all the old abuses with them. In England, where only the actual worker and not his dependents are covered by insurance, the average income of panel physicians from insurance is little over $2,000 a year, out of which he must pay the expenses of his practice. These physicians still have some private practice, but proposals now being considered to extend that system will further restrict this field of independent private practice. The panel physician is paid a little over $2 per person annually and must therefore have approximately 1,000 persons on his panel in order to receive $2,000. Payment for physicians under the English system is generally considered to be better than under any other system. The number of persons per physician in the United States is a little over 800.

14. What is the effect of insurance on graduate study of physicians?

Medical progress is so rapid as to require constant study by the physician who wishes to use the most approved methods of diagnosis and treat-

ment. Many state medical societies in the United States spend a considerable amount of their time and energy in furnishing their members with facilities for postgraduate study and in encouraging their members in all forms of professional improvement. Administrators of insurance systems also encourage a form of graduate study. They establish institutions to teach how to make out insurance reports, to detect malingering, to keep down the cost of prescribing and to meet the regulations provided by insurance. The physician who spends his time in this kind of study has little additional time left from his overworked insurance practice to keep up with scientific advance.

15. Has it been possible to apply a uniform health insurance system throughout the countries in which these systems have been adopted?

In nearly every country, local conditions have forced modifications of the general plan. The mountainous sections of Switzerland, the Highlands and Islands of Scotland, the farming sections of France and the miners of Germany are examples of conditions where the general system had to be greatly modified or entirely discarded to meet local conditions. There are as wide diversities in almost any of the states of the United States as are to be found in European countries. It is quite certain that the best possible general plan that could be devised could not be adjusted to all the varying conditions throughout the United States or even in different sections within many of the states.

16. Who have been the advocates of sickness insurance?

The most significant general fact is that in no country have either the physicians who are to give the service or the proposed beneficiaries of that service ever asked for it. In most countries its introduction was opposed by both groups. In a few countries in recent years, where voluntary insurance societies had been organized among laborers and found themselves in financial difficulties, these societies were able to secure the support of their members and sometimes of the political parties of labor for state subsidies and then for a compulsory system. The demand in these cases does not appear to have come from the membership but from the officials of the societies that were in financial difficulties and from the labor politicians who saw in the societies an extensive political machine. The first advocates of sickness insurance have almost always been social workers and philanthropists. These groups and individuals see in sickness insurance a simplification of their work in providing medical relief. Neither are they blind to the fact that the introduction of a system of sickness insurance will involve the employment of large numbers of such social workers.

17. Have sickness insurance systems become involved in politics?

In every country having such a system, the administrations of insurance have developed into powerful political machines. When benefits are distributed to individuals through an extensive administrative machinery with many employees, the whole scheme tends to become a gigantic political machine. This always has evil effects on the quality of the medical service. Patients are not able to judge the quality of medical service. They prefer free drugs to thorough diagnosis, and the politicians will give them what they want without regard to the effect on their health. This has been the tendency in nearly every system of sickness insurance.

18. What is the position of the organized medical profession on sickness insurance?

The medical profession has always maintained that its mission is to fight disease and guard the health of the people. It is to medicine and the scientific achievements encouraged by it that the world owes its amazing progress in the battle against disease. Organized medicine in the United States has been responsible for the origin of public health departments and the constantly rising standards of medical education, licensure and hospital practice. While every other occupation avows its mission to be the improvement of the economic conditions of its members, the medical profession has always insisted that its main mission is to protect the welfare of the individual and of the public. Individual physicians are human beings with all the weaknesses of human beings. But the organized profession has always maintained that the quality of medical service, the safeguarding of the public health, and the destruction of disease should be first. It is from this point of view and with a record of more than a thousand years of adherence to these principles that organized medicine approaches the question of insurance.

In no country has the organized medical profession declared itself against the principle of insurance as a method of payment for medical service. Nowhere has organized medicine based its position in regard to any medical question on economic grounds. The medical profession has not judged sickness insurance simply as a means for removing the economic obstacles to securing some sort of medical service. On the contrary, the medical profession views sickness insurance systems and proposals as a means by which lay interests, with a record that shows no such willingness to relinquish economic advantages as does the history of the medical profession, seek to gain control of the practice of medicine.

Medical associations in the United States are interested in the operation of insurance systems in all other countries, not so much from the economic

effect on physicians or patients (although this phase has not been neglected) but chiefly with regard to the character of the medical service given, its effect on the general health of the insured and its influence on the standards of medical practice. The medical associations of insurance countries have cooperated faithfully in trying to protect the health interests of the insured. It is significant that the advocates of insurance in the United States always offer as the best examples of insurance just those systems in which the medical associations, always only by hard fighting, succeeded in introducing provisions to safeguard the character of the medical service and to mitigate some of the evils inherent in sickness insurance. It is also significant that the same advocates oppose all proposals to include such safeguarding provisions in the schemes urged for the United States.

19. Has organized medicine been indifferent to the problem of medical care for the low income classes?

An estimate based on numerous though somewhat limited studies places the value of services donated by the physician of the United States to the care of the indigents and low income classes during the last few years at about one million dollars a day. Practically every institution offering service to these classes depends for its existence on the donated services of physicians. Reports from many studies indicate that in spite of the amount of medical care paid for at almost nominal rates by the FERA, by far the larger portion of the care actually received by the unemployed and many others not eligible to FERA benefits during the past year was given without charge by physicians. Certainly if there is any section of the people that has not been indifferent to the problem of medical care for indigents it has been the organized medical profession of the United States. State and county medical societies throughout the entire country are trying to find the best method of giving good medical care to those unable to pay for it. A number of the experiments that offer the best promise of meeting this situation have been originated and are now being conducted by such medical societies. In all this discussion and experimenting, the fundamental necessity of maintaining the conditions on which good medical service depends has been kept uppermost. These experiments have shown that many of the methods of furnishing medical service by some of the proposed systems destroy the fundamental conditions of good service. For that reason organized medicine has opposed or sharply criticized the wholesale plans offered by social workers, philanthropists, employers and laymen, very few of whom have proved their devotion to those in whose interest they claim to act by any such economic sacrifice as has been made by members of the medical profession.

Mailing Medicine

Some confusion has arisen relative to the postage required on packages or bottles of medicine mailed by physicians to patients.

At the request of several physicians, the matter has been taken up by the State Headquarters Office with Columbus postal authorities.

The postal authorities point out that the United States Postal Regulations make it mandatory that all written matter—by hand or typewriter—carry first-class postage.

This regulation applies to medicine in envelopes or a bottle to which a label of directions, written by hand or typewritten, is attached. Medicine carrying printed labels—patent medicines—may be mailed at parcel post rates.

To avoid having to pay first-class postage on medicine sent through the mails to patients, it is suggested physicians adopt the following procedure:

In mailing a bottle or envelope of medicine, *do not* attach a label of directions to the bottle or envelope. Wrap the bottle or envelope containing the medicine, properly address the package and attach sufficient parcel post postage. *Place the label of directions in a separate envelope.* Seal and properly address the envelope, and attach first-class postage—2 or 3 cents depending on whether it is or is not for local delivery. Then, place the sealed envelope containing the label of directions under the twine about the bottle or envelope of medicine and mail the package. The package and the envelope will be delivered together. The only first-class mailing charge will be the 2 or 3 cents placed on the envelope.

The physician should be sure that the package of medicine and the envelope containing the directions are each addressed as if it were being mailed separately and that each carries the correct amount of postage—the package or bottle parcel post postage and the envelope first-class postage.

— OSMJ —

Among the last official acts of Governor White, before his retirement on January 14, was the appointment of Dr. H. G. Southard, Marysville, retiring State Director of Health, as a member of the Ohio Public Health Council, for the term expiring June 30, 1938, and the reappointment of Dr. G. D. Loomis, Middletown, for the term expiring June 30, 1937. Dr. Southard fills the place on the Council vacated through the death of Dr. C. O. Probst, Columbus. The appointments were presented to the State Senate for confirmation.

— OSMJ —

Ironton—When the stork paid his fifteenth visit to the home of Mr. and Mrs. Jesse White recently, Dr. Wilson Lynd was on hand to assist him as he had on fourteen previous visits. Eleven of the 15 White youngsters, all delivered by Dr. Lynd, are living.

CHANGES IN LOCAL HEALTH, WELFARE SET-UPS AND CORONER SYSTEM SUGGESTED BY COMMISSION ON COUNTY GOVERNMENT

ESTABLISHMENT of public health service as a county function, to be administered by a county health department as a component unit of county government; concentration of all relief and welfare activities within a county, except those properly belonging to a department of health, in a single county welfare department; and, abolishment of the office of county coroner and transfer of the legal duties of that office to a medical examiner, appointed by and operating under the county prosecutor, are among the numerous suggestions for reorganization of county government in Ohio made in a 190-page report, submitted December 28, 1934, to Former Governor George White by a Commission on County Government appointed by him late in 1933.

The Commission was appointed by Governor White to study problems involved in the reorganization of county government and to draft measures necessary for carrying out the purposes of the amendment to Article 10 of the Constitution of the State of Ohio, adopted November 7, 1933, which authorizes the General Assembly to provide by law for the reorganization of county government and set up optional forms of county government, any one or combination of which may be adopted by any county upon vote of the people. (See November, 1934, issue *The Journal*, pages 769-772).

The personnel of the Commission was: Charles P. Taft, 2nd, chairman, Paul Belden, Harold Burton, Charles E. Chittenden, Carl Friebolin, Robert Gorman, Robert Guinther, Francis W. Kennedy, Walter F. Kirk, Murray D. Lincoln, Mark Selby and Mr. N. M. Stanley. R. C. Atkinson served the Commission as secretary and director of research. The survey of the Commission on public health administration was made by Dr. Joseph W. Mountin of the staff of the United States Public Health Service.

THREE OPTIONAL PLANS PROPOSED

The general conclusion arrived at by the Commission, following a comprehensive study of present forms of county government in the state, is that "drastic changes in organization are essential if the county is to be made an efficient instrument of local government".

"The present system, which has developed through generations of planless growth, is much too cumbersome for the effective performance of the services now entrusted to it", the report states.

The Commission recommends three forms of organization for county government which, in its judgment, are the best adapted to the needs of Ohio counties:

1. The county manager plan under which the board of county commissioners appoints and removes the manager who in turn appoints and removes the heads of departments and is responsible to the board and through it to the community for the administration of county affairs.

2. The limited executive plan under which the chief executive is appointed by and responsible to the board of county commissioners but department heads are appointed and removed by the board on recommendation of the executive officer.

3. The elective executive plan under which the chief executive is elected for a four-year term, subject to recall, and is given power to appoint and remove department heads.

SITUATION OF HEALTH SERVICE "ANOMALOUS"

Five administrative departments are provided in the foregoing plans: Finance, law enforcement, public welfare, public works, and recording and court service.

Public health service is not now included because, as the report points out, "the legal status of health districts is now somewhat anomalous". The Commission found that general and city health districts, as defined in recent court decisions, are administrative districts of the state and are not part of county and municipal government, although in practice a city health district functions as a part of city government.

However, the Commission strongly recommends that the powers and duties of general health districts and the health functions of cities, city health districts and townships be transferred as soon as possible to counties, pointing out that as soon as this is accomplished it will be feasible and desirable to incorporate a "County Department of Health" as another unit in proposed plans of county government.

LEGISLATIVE PROPOSALS PREPARED

To follow up its study and report, the Commission is planning to sponsor at the 91st session of the State Legislature, which convened on January 7, proposals incorporating its major recommendations.

A proposed *optional* county government act will be introduced giving counties authority, upon vote of the electorate, to set up any one of the

three optional organization plans suggested by the Commission.

Also, the Commission is planning to sponsor single proposals which would permit counties, which do not adopt any of the three optional plans or charters incorporating the basic provisions of those plans, to abolish certain offices and consolidate the functions and activities of existing offices, thus allowing simplification of county government in counties which do not choose to adopt a complete plan of reorganization.

All proposals dealing with county government reorganization sponsored by the Commission will be *optional in form* and even if enacted by the Legislature will become effective *only after approval of the voters* of the respective counties where changes in county government set-ups are sought.

HEALTH DEPARTMENT PROPOSAL

That section of the general recommendations of the Commission which deals with public health states:

"The county should be developed as the local unit for health administration. The powers and duties of general health districts should be transferred to counties at once and the health functions of cities, city health districts, and townships, as soon as feasible. Most existing health districts are too small for efficient performance of health service at reasonable cost. Moreover, the general health district as now set up is cut off from effective governmental control and lacks a sound basis of financing. The depression has already demonstrated that townships and cities are not large enough, as a rule, for the financing of medical and hospital care of the poor. The county is also nearer the size required for economical hospital operation. When the functions of the general health district are transferred to the county, a county department of health should be created for their administration and for the conduct of any hospitals, sanatoria, and other health services maintained by the county."

SET-UP FOR HEALTH SERVICE FORMULATED

Regarding the plan of administration of a county department of health, if and when created, the Commission recommends:

1. Creation of a board of health as a stabilizing and coordinating body, appointed by the chief executive of the county or, if there is no chief executive, by the county commissioners.
2. The powers of the board should be limited to determining policies of the department and passing on the appointment and removal of personnel.
3. Administration of the department should be vested in a medical officer of health, appointed for an indefinite tenure, (a) in counties having a chief executive, by the chief executive on the recommendation of the board of health; and (b) in other counties, directly by the board of health.
4. Administrative authority in matters of health should be vested in the medical officer of health.
5. Ordinance-making powers in the field of health and the power of appropriation of funds for health purposes should be vested in the legislative authority of the county.
6. Other agencies, such as the county department of welfare and the schools, responsible for activities in which health service is incidental, should utilize the department of health so far as possible in the provision of such service.

VARIED RESPONSIBILITIES CITED

Approximately 25 pages of the report are devoted to a discussion of public health problems and recommendations for reorganizing public health administration on a county basis.

The Commission found during an extensive survey of representative counties that there is a wide and varied distribution of local responsibility in the field of public health. Quoting from the report:

"The regularly elected officials of the county government have comparatively few responsibilities in relation to health. Neither is there any central direction or coordination of program. General and city district boards of health have budgetary and administrative responsibility for only a small part of the tax-supported services in the interests of health. Other elements of the general program have been an outgrowth of relief and custodial measures. Certain of these responsibilities are retained by municipalities and townships, while others have been delegated to special boards and commissions which operate on a county-wide basis. There is considerable difference with respect to the kind and amount of service supplied in the several counties of the state, yet the plans of administration are quite similar."

The report enumerates the branches of local government to which some phases of public health service have been allocated, namely: Board of health, board of education, board of trustees of county hospital, board of trustees of county tuberculosis hospital, board of trustees of county children's home or child welfare board, county commissioners, county auditor, county emergency relief director, juvenile court, county coroner, municipalities and township trustees.

FINDINGS AND RECOMMENDATIONS SUMMARIZED

The following excerpts from the report present some of the problems confronting public health administration in Ohio; some of the important data assembled by the Commission on the present system of public health service; the Commission's reasons for recommending reorganization of

local public health administration on a county-wide basis; the advantages and benefits which, in the Commission's opinion, would accrue from such reorganization; and the various methods which should be used to set up the plan suggested by the Commission:

"If public health be defined to include any tax-supported service in the interest of human health, it will be found that services designated for this purpose are widely scattered through the whole structure of local government. The regulatory and educational functions are centered in boards of health operating on a district basis; hospitals and sanatora may be maintained by either the counties or the municipalities but they are usually operated by special boards; and other elements of health service have for the most part grown out of relief and custodial responsibilities of county, municipal and township governments. The health services maintained by local governments are seldom found to have passed even a rudimentary stage of development. This is to be expected since health has never been a major political issue; and as yet, there is no clear-cut social policy with regard to desirable forms and extent of government participation.

"The nature of the public health problem is changing. Boards of health were organized originally to control epidemic diseases and to promote sanitation. However, law enforcement in these matters has gradually been replaced by education; and epidemics susceptible to control, though possible still, seldom occur and rarely reach alarming proportions. In addition, the development of the esthetic sense together with the desire for comfort and convenience have become strong factors in promoting community facilities such as sewer and water systems which largely solve problems of municipal and to a lesser extent rural sanitation. Thus, health is rapidly becoming a matter of personal hygiene and medical care. At the same time, the growing load of dependency together with the desire on the part of the low-income class to participate in the benefits of advanced medical science have forced the community to accept larger responsibilities for medical and custodial care. In the case of many services, especially hospitals, the basis of support is being transferred from private philanthropy to taxation. It is evident, therefore, that the maintenance of the more expensive facilities, such as hospitals and sanatora, and the provision of various forms of medical service for the poor will constitute a larger part of the public health program in the future, and that the traditional regulatory and educational activities of boards of health will become relatively less important.

UNIFIED DIRECTION ESSENTIAL

"Assuming that these social trends are to continue, it behooves government to make such administrative adjustments as may seem advisable and expedient in the interest of better service as well as greater efficiency and economy. It is but logical that these objectives should be accomplished by bringing together under unified direction those services which employ persons trained in the medical and sanitary sciences and by distributing the cost of a comprehensive program over larger units of population than has hitherto been the practice. In discussing possible plans for health administration in county government, it is necessary, first, to consider the peculiar requirements of the service to be performed from the human standpoint and, second, the method by which the service can be fitted into the structure of government so as to insure economical operation.

"Health is neither a clear-cut nor a well-established function of government, but rather a purpose which must be accomplished by coordinating the efforts of many agencies of the community. This coordinating influence naturally should emanate from some central agency having a staff trained in the biological sciences on which medicine and sanitation are based. Such a department of health should be under the direction of a medical officer of health with at least a minimum of training and experience in public health administration to be defined by the state public health council. Provision should be made in the budget for an adequate staff of nurses, sanitarians, and such other technical and clerical assistants as may be required.

"The health department should discharge the regulatory, educational, and preventive medical services of boards of health as now organized; operate institutions, such as hospitals, clinics, and sanatora, which render a medical service exclusively; and assist other departments of the local government in which health service of any type may be an incidental requirement. By such a plan of administration, it is possible to bring under unified professional direction several services which are closely related as to content, purpose, and personnel involved in their performance.

REVENUE PROBLEMS DISCUSSED

"In the larger units of population, approximately one dollar per capita will be required annually by the health department for the discharge of those regulatory and educational responsibilities which are now imposed by state law on boards of health. If units of population below 25,000 are to be retained for purposes of health administration, the per capita costs naturally will be higher. Provision must also be made in the budget of the health department for the support of such hospitals, sanatora and other forms of medical service as may be provided at public expense.

"Taxable resources, population, and unit of government are three distinct but closely related factors which must be considered in developing a comprehensive health service. Such a compre-

hensive health service should include the regulatory, educational and preventive medical services now performed by the more liberally supported boards of health, together with such hospital, sanatorium and clinical facilities as may be required.

"If these services are desired, certain minimum costs must be accepted. These amounts will prove excessive for all the townships, all but the larger municipalities, and perhaps for a few of the counties. Furthermore, there is no necessity of having a hospital, a sanatorium and an administrative organization in every local subdivision of the state. From the standpoint of taxable resources and population, it would be desirable, theroetically at least, to organize health service on the basis of trade areas around the commercial centers providing wherever possible for units of 50,000 or more in population. This, however, would not be feasible without state financing and state operation. Other administrative considerations dictate the use of another unit of government.

"An existing unit of government with well-established traditions is preferable to one especially created for the performance of a specific function, since all the powers of government, including taxation, ordinance-making, and law enforcement, are required in health administration. The unit to be selected for health administration, for reasons already stated, must contain sufficient population and taxable wealth to provide for economical operation and a stable basis of support.

COUNTY TERMED LOGICAL UNIT

"The health districts as now organized do not fulfill these requirements. From the standpoint of population, the majority are too small for satisfactory service unless provided at excessive cost. Seventy per cent of the city health districts and 37 per cent of the general health districts contain less than 20,000 inhabitants; 44 per cent of the city health districts are below 10,000 in population. tion. Moreover, the legal position of health districts is not sufficiently identified with local government in that they are construed by courts to be separate administrative districts of the state. Any enlargement of their functions would entail a transfer of powers and duties now vested in counties, townships, cities and villages. The health districts also have no powers of taxation, but must derive their revenue from the political units they serve. The general health districts, in particular, are at a disadvantage since they are supported by villages and townships which, as a rule, have rather limited income through taxation. Most districts can never be very effective since they are not self-contained from the standpoint of the social and economic life of the people. Many problems in health arise from factors which disregard local boundaries and their solution necessitates the utilization of greater resources than can be found in most of the existing health districts.

"On the other hand, most of the counties meet the requirements specified above for effective and economical health administration in a substantial measure. The county already has powers of law enforcement, and, under the proposed plan of reorganization, ordinance power will be enlarged. It may levy and collect taxes on the county as a whole; and the majority of counties contain sufficient population and taxable wealth over which the cost of service may be distributed. The county is well established as a unit of government and steps have already been taken to utilize it for the administration of medical services, a responsibility which probably will grow in importance and continue to be the most expensive part of the public health program.

"In the smaller counties, especially those with populations of less than 25,000, it is not, as a rule, feasible to provide many of the services which are considered essential in modern health administration; and, if provided, the per capita cost is much higher than when maintained by units of greater size. The present health law permits voluntary union of health districts and the principle should be retained. But the experience thus far indicates that counties rarely are willing to take advantage of the possibility for such union. A differential plan of state aid might be devised which would encourage such a union; otherwise, the alternative in a number of counties will be a low standard of service locally administered, or the transfer of responsibility to the state."

CONCENTRATION OF WELFARE ACTIVITIES

Great stress is made in the Commission's report relative to the need for unification of activities and concentration of authority in the field of local public welfare through the establishment of a single county department of welfare, provision for which is made in the optional forms of county government suggested by the Commission.

Responsibility of providing medical care for the poor would be delegated to the proposed county welfare department. However, such a department would not take over or administer services which properly belong to a department of health.

"Welfare is at present the most costly and the most disjointed function administered through the county," it is stated.

"Excluding the operation of hospitals and the provision of tuberculosis care, which are treated as public health activities, welfare may be deemed to include those services designed for the care of dependents and defectives and the treatment or custody of delinquents. Together, these services represented an expenditure of $31,267,000 in 1933 —much of which was financed, of course, from state and federal sources—and made up 42 per cent of the total expended for county purposes.

* * * Prior to the depression welfare ranked second among county functions in point of expense, and the number of persons provided for ranged between 50,000 and 70,000 a year. No other county function is administered through so elaborate an array of independent agencies as is welfare. Authority is divided by law among five different boards or commissions, two elective offices, and three appointive positions. In the average county there are at least eight such agencies engaged in the conduct of welfare services."

DEFECTS IN PRESENT SYSTEM REVIEWED

The report reviews the roles and functions of the various governmental units in public welfare; the organization and scope of county services, etc., pointing out what, in the Commission's judgment, are serious defects in the existing system of local welfare administration:

1. Responsibility is divided among too many overlapping governmental units some of which do not have sufficient financial resources to meet their relief obligations properly even in ordinary times.
2. There is much overlapping of jurisdiction and some duplication of service.
3. There is almost no machinery for developing or securing the execution of a consistent welfare program and no one official with general authority over county welfare services.
4. The division of welfare work among numerous independent agencies makes it financially impractical in many instances to employ competent persons.

It is pointed out that the depression has brought about, temporarily at least, some important changes in the role of the various governmental units in the care of the poor. The financing of emergency unemployment relief has passed from cities and townships largely to the state and federal governments. The administration of such relief has been transferred from cities and townships to county relief offices, which are virtually directed by the State Relief Commission. Moreover, the state has permanently entered the dependency field through the establishment of old age pensions, using the county as the local administrative unit.

COUNTY MOST SUITABLE UNIT

"As a permanent arrangement local responsibility for the care of dependents should be definitely vested in one governmental unit of sufficient size to permit competent administration and a substantial measure of financial support," the report declares. The division of the field among different governments within the same area leads to difficulties and at best interferes with an effective handling of the problem.

"It is now the general opinion of persons experienced in welfare administration that the county is, as a rule, the most suitable local unit for the care of the poor. ***

"It is recommended, therefore, that the authority to provide non-institutional care of the poor, now vested in the county by temporary legislation, be made permanent; and that as soon as practicable the powers and duties of townships and cities as to the care of dependents be transferred entirely to the county. On a temporary basis, this transfer has already been nearly completed insofar as cities are concerned and largely accomplished in the case of townships. When the present emergency has passed there will still be a large and difficult relief problem to be dealt with. It would be unfortunate if the training and experience gained by county relief workers during the emergency period were scrapped and relief administration thrown back upon the townships and cities when business conditions improve."

SUMMARY OE RECOMMENDATIONS

In brief, the Commission's recommendations on the question of local welfare administration are:

1. The county should be given permanent authority to provide non-institutional care of the poor and should be made the local unit for welfare administration.
2. County charters and optional plans of county government should provide for a department of welfare having (1) the administration of all institutions and non-institutional services for the care of dependents, *other than services properly belonging to a department of health;* (2) the operation of any correctional institutions, other than jails, maintained by the county; (3) the authority to render probation service to any court within the county upon its request.
3. Board of county commissioners should be authorized to establish welfare departments along the lines indicated in counties not adopting charters or optional plans.
4. Where a county welfare department is created, it should take over the functions of the county board of aid for the aged and its employes in the administration of old age pensions, and the state should have the right to use the department as its agent in the administ of state-financed relief or state welfare services requiring the maintenance of local offices or agencies.
5. A county department of welfare should consist of a director of welfare, an unpaid board of welfare, and the necessary personnel.
6. The board of welfare should be appointed for over-lapping terms by the chief executive of the county, or, if there is no such officer, by the board of county commissioners. The board of welfare should perform the functions assigned by law to the board of aid for the aged and the board of county visitors, and should

advise the director in the conduct of the department.

7. The director of welfare should be appointed by the chief executive of the county or, if there is no such officer, by the board of welfare, from persons pre-qualified by the state department of welfare in accordance with standards prescribed by it for heads of local agencies administering state-financed welfare services. The director should have immediate charge of the operation of the department and the appointment of subordinates.

WANT CORONER SYSTEM ABOLISHED

A sweeping reorganization in the medical phases of law enforcement activity in a county, through general law applying to all counties and through incorporation of reforms in charters and optional reorganization plans, is outlined in the report.

The Commission recommends that such legislation should:

1. Abolish the office of coroner.
2. Transfer to the prosecuting attorney the responsibility for examining witnesses and conducting the legal part of the investigation where crime is suspected or known to have occurred.
3. Create the position of medical examiner, to be filled by appointment within the classified service unless the county health officer is designated as such, the appointing authority being vested in the prosecuting attorney or the head of the department of law enforcement, if any.
4. Eliminate the provisions as to the coroner acting in place of the sheriff.

It is pointed out that the possession of a license to practice medicine in the state should be prescribed by statute as a minimum qualification for the position of medical examiner, and special training in pathology should be required by the civil service commission so far as practicable.

"There are a number of serious objections to the coroner system as it exists in this state," the report says.

"In the first place, a large per cent of the persons elected coroners lack the essential qualifications for performing the duties of the office. At least 33 of the 88 coroners of the state are not members of the medical profession, though their principal function is to determine the cause of death. In many cases the office is held by undertakers whose interest is obviously commercial. As a result of this condition, the work of the office is frequently valueless or positively detrimental to law enforcement.

"A second and more fundamental defect in the system is the combination of legal and medical duties requiring totally different qualifications which are rarely possessed by the same person.***

"A third objection to the present system is the lack of coordination with other law enforcement agencies, namely, the prosecutor and the police or sheriff, whose work is often impeded by the acts of the coroner."

THREE PRINCIPLES OBSERVED

The Commission states that in formulating the previously enumerated recommendations three principles were observed, namely: The technical legal and medical duties be separated and assigned to persons having the appropriate professional qualifications for their performance; the work should be correlated as closely as possible with other law enforcement agencies; the method of choosing professional personnel should be such as to encourage selection on the basis of fitness and to favor stability of tenure.

Concluding this chapter of its report, the Commission said:

"It is recognized that a county medical examiner system does not afford a complete solution of the problem in rural counties, for the reason that the general practitioner does not possess, as a rule, the specialized training required for the determination of death in some cases. It would seem that this difficulty calls for the provision of such specialized service by the state government to supplement that of the local medical examiner where needed."

— OSMJ —

Budget Requests Submitted By Various State Departments

Funds aggregating approximately $116,000,000 for operating, maintenance and improvements during 1935 and 1936 are sought in budget requests submitted to the State Finance Department by various state departments, institutions, boards, commissions, etc.

These requests are now in the hands of the Budget Director where they may be reduced before being submitted to the General Assembly.

Among the appropriations sought are the following: State Department of Health, $1,145,000, including $600,000 for state subsidies to various local health districts; State Department of Public Welfare, $18,147,640, including $15,839,840 for operating expenses and maintenance and $2,307,800 for improvements and betterments of various state welfare and penal institutions; State Industrial Commission, $3,016,000.

— OSMJ —

—Officers have been elected as follows by the staff of St. Elizabeth's Hospital, Youngstown: President, Dr. C. D. Hauser; vice president, Dr. E. W. Coe; secretary-treasurer, Dr. Saul Tamarkin; director of medicine, Dr. A. M. Rosenblum; director of surgery, Dr. F. W. McNamara; member of executive committee, Dr. L. G. Coe.

WORKMEN'S COMPENSATION

Digest of Recent Court Decisions and Excerpts of Interest to Physicians Pertaining to Industrial Commission Cases and Administrative Procedure.

Governor's Committee Makes Final Report

A 52-page report, supplemented by a 66-page actuarial survey, pointing out weaknesses in the administration of the Ohio Workmen's Compensation Law; deficiencies in the statutory provisions on which the Ohio workmen's compensation system is based; and recommending changes in the law itself and numerous ways of improving the administrative machinery, was released by the Governor's Investigating Committee on Workmen's Compensation as this issue of *The Journal* was about to go to press.

As anticipated, the report is of special interest to members of the medical profession, inasmuch as an important part of the report deals with medical problems arising from administration and operation of the workmen's compensation system, and incorporates some of the constructive recommendations made to the investigating committee by the Ohio State Medical Association (May, 1934, issue *The Journal*, pages 318-320; also March, 1934, issue, pages 171-173; June, 1934, issue, pages 387-388; August, 1934, issue, pages 530-531).

The report will be reviewed in detail in the March issue of *The Journal* it being impossible at this time to publish more than some of the major recommendations of the committee which are of special interest to the medical profession, namely, that:

1. The work of investigation and adjustication of claims decentralized under one of the following plans or combinations of such plans: (a) Increasing the membership of the State Industrial Commission and investigation and medical staffs; (b) establishment of district boards of claims of commissioners each composed of three members on a district basis; (3) setting up of 10 or 12 district headquarters under a deputy commissioner and with adequate personnel to make investigations, hold hearings and render decisions, subject to appeal to the Industrial Commission.

2. Provision for enlarged and more efficient personnel in the medical department of the Commission.

3. Authority for the Commission to establish medical boards of review in different sections of the state to review and pass on the medical testimony in disputed and complicated cases, one of the recommendations made to the Committee by thy Ohio State Medical Association.

4. Facilities established for effecting physical rehabilitation of disabled claimants and an adequate rehabilitation fund set up for this purpose.

5. Hospital facilities secured by the Commission for the observation and treatment of special cases.

6. Increased emphasis given to the matter of accident prevention.

7. The Commission authorized to appoint an advisory council to assist the Commission in the execution of its powers and duties; make investigations of administrative details; and recommend from time to time statutory and administrative changes.

8. Salaries of major and more important personnel such as to make it possible to obtain the competence and quality necessary for the administation of highly important insurance business.

9. Modification of the civil service requirements to permit more careful selection of personnel on the basis of quality, efficiency and training.

10. Legislation to provide immunity from prosecution for physicians who in the course of their professional duty furnish medical information in reports covering any case to the Industrial Commission.

11. More adequate funds made available by the Legislature for administration of the compensation law.

* * *

Persons employed in manufacturing plants being operated on funds supplied by and under the supervisions of the Ohio Relief Production Units, Inc., a corporation not for profit, the incorporators of which are members of the State Relief Commission, are entitled to the benefits of the Ohio Workmen's Compensation Law in case of injury or disability arising from their employment, Attorney General John W. Bricker has ruled in an opinion (No. 3632) rendered to the State Industrial Commission.

At present some 900 persons are employed in approximately 12 such manufacturing plants being operated in various parts of Ohio by the Ohio Relief Production Units, Inc. These employes are paid daily wages and are producing commodities which are sold to various county relief administrations at market prices for distribution to families on relief.

Study Outline No. 8

ABORTION

By THEODORE MILLER, M.D.,
CLEVELAND, OHIO

Abortion includes any loss of the ovum before the twenty-eighth week.

1. Mortality and Morbidity.
   - A. One-third of all deaths of puerperal women due to abortion. Later operative sequelae increase this number.
   - B. About fifteen per cent of those who survive are left with some pathological consequence. (Russian Statistics).
   - C. Estimated that in this country about one out of four pregnancies terminates in an abortion.
2. Causes.
   - A. An imperfect ovum.
   - B. Maternal abnormality or illness.
     1. Congenital.
     2. Due to tumor.
     3. Due to infection.
   - C. Direct injury to ovum.
     1. Accidental. (rare)
     2. Abortificants. (uncertain)
     3. Mechanical removal. (curettage)
     4. Mechanical irritation. (catheter)
        This depends largely upon infection.
     5. *X*-ray. (uncertain)
3. Symptoms.
   - A. Flowing. With or without the pain from uterine contractions.
   - B. Cramps from uterine contractions.
     May occur without bleeding.
4. Diagnosis.
   - A. Eliminate other causes of uterine bleeding.
     Examine as gently and as infrequently as possible. The Freedman test of urine occasionally helpful.
   - B. If there be a pregnancy.
     1. Continued bleeding.
     2. Uterine contractions.
     3. Gapping cervix.
   - C. Threatened.
     1. Slight bleeding.
     2. Uterine contraction.
   - D. Inevitable.
     Prolongation of the above symptoms.
     Plus an open cervix.
5. Prophylaxis.
   - A. Rest in bed until long after symptoms have disappeared.
     Narcotics may aid. Oxytoxics not to be given.
6. Pathological Sequelae.
   - A. Infection.
     1. Endo-metritis.
     2. Metritis.
     3. Para-metritis.
     4. Pelvic abscess.
     5. Peritonitis.
     6. Phlebitis.
     7. Septicaemia.
   - B. Impairment of function due to mechanical interference.
7. Treatment.
   - A. Afebrile clean individuals.
     1. No interference except for severe bleeding. Very few die if there be no manipulation.
     2. Remove the ovum with the finger if loosened.
     3. Curette for bleeding only.
        An undilated cervix usually forbids curettage.
     4. Pack the uterus only for bleeding following curettage.
     5. Do not use the intra-uterine douche.
   - B. Infected individuals with fever.
     1. The cervix must be open before manipulation.
     2. Remove loose infected products from the uterine cavity with the finger, or from the lower segment with a ring forceps.
     3. Pack the cavity with gauze, (iodoform) for bleeding.
     4. Do not use a sharp curette or any sort of placental forceps.
   - C. Administer 1 c/c of pituitrin before operation.
   - D. Transfuse for anaemia.
   - E. In infected individuals.
     1. Promote drainage.
     2. Ice packs to the lower abdomen.
     3. Morphine.
     4. Small repeated transfusions.
     5. Sera of very doubtful value.
     6. Do not operate for the removal of presumably infected tissue.
     7. Drain abscess below or above when pus is accessible.
     8. If a therapeutic abortion is to be done, it must be accomplished before the patient is in extremis.

SUGGESTIONS FOR PAPERS

1. The Diagnosis of Abortion.
2. The Time and Method of Choice for Emptying the Uterus.
3. The Treatment of Sepsis Following Abortion.
4. The Indications for Therapeutic Abortion.

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First District

ACADEMY OF MEDICINE OF CINCINNATI

(H. J. Lavender, M.D., Secretary)

January 7—General Session. Program: "Cystic Mastitis: Its Causes and Treatment", Dr. Dean Lewis, professor of surgery, Johns Hopkins University, Baltimore.

January 14—General Session. Program: Address by Colonel Henry M. Waite, director, Cincinnati Employment Center of the U. S. Regional Department of Economic Security; "The Concept of Hypersensitivity", Dr. Charlotte Wiedemer; "Bronchial Asthma", Dr. Albert R. Zoss; "Sneezing", Dr. Joseph B. Biederman; discussants, Dr. Joseph Stein and Dr. Stanley Dorst.

January 21 — General Session. Program: "Darkfield Illumination", Dr. Charles Goosmann; "Surgery of the Thorax—Discussion of the Problems and Presentation of Cases", Dr. B. N. Carter; discussants, Dr. Vera Norton and Dr. David Heusinkveld.

January 28—General Session. Program: "The Use of Alum Precipitated Toxoid in Diphtheria Immunization", Dr. Leo S. Friedman; discussants, Dr. A. Graeme Mitchell and Dr. J. V. Greenebaum; "The Prevention of Uterine Cancer", Dr. J. Hofbauer; discussants, Dr. R. S. Austin and Dr. Frank Coppock.

Butler County Medical Society in session December 13 at Mercy Hospital, Hamilton, elected the following officers: President, Dr. H. A. Moore, Oxford; vice president, Dr. W. T. Stewart, Oxford; secretary-treasurer, Dr. V. E. Roden, Hamilton; legislative committeeman, Dr. E. T. Storer, Middletown; medical defense committeeman, Dr. H. M. Lowell, Hamilton; delegate and alternate, Dr. M. O. Cook, Hamilton, and Dr. W. E. Griffith, Hamilton, respectively. The problems of poor relief were discussed. A special committee reported that the local relief director had refused to provide sufficient funds from his appropriations for compensating physicians under the fee schedule for services to the poor. The committee was instructed to continue its efforts to have the relief administration correct this situation and demand that adequate funds be provided for medical services.—V. E. Roden, M.D., Secretary.

Clinton County Medical Society met December 11 at the General Denver Hotel, Wilmington, and elected the following officers: President, Dr. A. C. Roberts, Wilmington; vice president, Dr. C. E. Kinzel, Wilmington; secretary-treasurer, Dr. V. E. Hutchens, Wilmington. The society endorsed the immunization and vaccination campaign of the city and county health departments.—News Clipping.

Highland County Medical Society has elected the following officers for the ensuing year: President, Dr. H. H. Lowe, Leesburg; vice president, Dr. J. H. Frame, Highland; secretary-treasurer, Dr. W. B. Roads, Hillsboro; legislative and medical defense committeeman, Dr. J. C. Larkin, Hillsboro; delegate, Dr. H. W. Chaney, Sugar Tree Ridge; alternate, Dr. K. R. Teachnor, Leesburg.—W. B. Roads, M.D., Secretary.

Second District

Champaign County Medical Society, in session December 13, reorganized for the ensuing year. Dr. W. A. Yinger, Rosewood, was installed as president. The following officers were elected: President-elect, Dr. L. A. Woodburn, Urbana; secretary-treasurer, Dr. Forrest E. Lowry, Urbana; legislative committeeman, Dr. D. C. Houser, Urbana; medical defense committeeman, Dr. N. M. Rhodes, Urbana; delegate, Dr. Houser; alternate, Dr. Woodburn; censors, Dr. J. W. Norman, St. Paris; Dr. Mark Houston, Urbana, and Dr. E. D. Buhrer, Urbana; hospital committee, Dr. Lewis Inskeep, Urbana, Dr. Richard Henderson, Urbana, and Dr. D. H. Moore, Urbana.—L. A. Woodburn, M.D., retiring secretary.

Darke County Medical Society was addressed on December 21 at a dinner meeting at the Christian Church, Greenville, by Dr. Albert L. Brown, Cincinnati, on "Common Eye Conditions in General Diseases". At the business session, the following officers were elected: President, Dr. J. W. Van Lue, Gettysburg; vice president, Dr. J. R. Alley, Greenville; secretary-treasurer, Dr. W. D. Bishop, Greenville; legislative committeeman, Dr. J. E. Hunter, Greenville; medical defense committeeman, Dr. O. P. Wolverton, Greenville; delegate, Dr. C. I. Stephen, Ansonia; alternate, Dr. J. E. Gillette, Versailles.

At its meeting January 18, the society was addressed by Dr. S. H. Ashmun, Dayton, on "The Present Status of Immunization".—W. D. Bishop, M.D., Secretary.

Greene County Medical Society had as its guest speaker on January 3, Dr. Roy D. Arn, Dayton, formerly of Springfield. Dr. Arn spoke on "Surgery of the Sympathetic Nervous System".—Reyburn McClellan, M.D., Secretary.

Miami and Shelby County Medical Societies held a joint meeting January 3 at the Stouder Memorial Hospital, Troy. Following a luncheon, Dr. John A. Caldwell, Cincinnati, president of the Ohio State Medical Association, addressed

the society on "Head Injuries". Among the 45 attending was Dr. E. M. Huston, Dayton, councilor of the Second District.—Bulletin.

Montgomery County Medical Society was addressed on January 4 by Dr. W. M. Simpson on "Progress in Artificial Fever Therapy Researches", and Dr. A. M. Culler on "Artificial Fever Therapy of Ocular Syphilis". The papers were discussed by Dr. E. L. Hooper.

On January 18, Dr. W. R. Hochwalt spoke on "Low Back Pain of Mechanical Origin", and Dr. H. D. Cassel on "Symptomatic Back Pain". Dr. H. H. Wagner led the discussion which followed. —Bulletin.

Preble County Medical Society in session at the Seven Mile Tavern, Eaton, December 20, was addressed by Dr. M. O. Cook, Hamilton, on "Arterio-Venous Anuerism".

Dr. R. K. Finley, Dayton, addressed the society on January 17 on "Surgery of the Hand".—Bulletin.

Third District

Allen County—Academy of Medicine of Lima and Allen County has elected the following officers for 1935: President, Dr. W. A. Noble, Lima; vice president, Dr. R. E. Bushong, Lima; secretary, Dr. H. C. Weisenbarger, Lima; treasurer, Dr. J. B. Poling, Lima; correspondent, Dr. W. V. Parent, Lima; legislative committeeman, Dr. Poling; medical defense committeeman, Dr. William Roush, Lima; delegate, Dr. C. L. Steer, Lima; alternate, Dr. H. L. Basinger.

Hancock County Medical Society met in regular session January 3 at the Elks' Club, Findlay. Dr. W. H. Meffley, Toledo, made an interesting illustrated address on "Radium Treatment of Cervical and Superficial Malignancies".—R. S. Rilling, M.D., Secretary.

Hardin County Medical Society, in session December 20 at Kenton, elected the following officers: President, Dr. C. S. Jackson, Kenton; vice president, Dr. G. S. Wilcox, Ada; secretary-treasurer, Dr. W. N. Mundy, Forest; legislative committeeman, Dr. F. M. Elliott, Ada; medical defense committeeman, Dr. R. G. Schutte, Kenton; delegate, Dr. Don R. Printz, Ada; alternate, Dr. C. L. Johnson, Kenton. The scientific program was presented by Drs. Carll Mundy, James McGun and Lawrence Miller, of Toledo. Allan Ocs, relief director of Hardin County, spoke on the activities of his department.—W. N. Mundy, M.D., Secretary.

Marion County—The Academy of Medicine of Marion was addressed on January 8 by Dr. Milton B. Cohen, Cleveland. Dr. Cohen spoke on "The Significance of Allergic Reactions in the Symptomotology of Medical and Surgical Conditions". —News Clipping.

Mercer County Medical Society was entertained at the Lion's Den, Celina, by Drs. L. N. Schroder, E. J. Willke and L. M. Otis. Following dinner, officers were elected for the ensuing year, as follows: President, Dr. L. M. Otis, Celina; vice president, Dr. E. J. Willke, Maria Stein; secretary-treasurer, Dr. Frank E. Ayers, Celina; legislative committeeman, Dr. M. L. Downing, Rockford; medical defense committeeman, Dr. T. J. Gibbons, Celina; delegate, Dr. Ralph Beare, Celina; alternate, Dr. L. N. Schroder, Ft. Recovery. The program was presented by Dr. Otis, who spoke on "Diathermy Pneumonia". Following the meeting, the members and their wives were entertained at the Otis residence.—Frank E. Ayers, M.D., Secretary.

Fourth District

TOLEDO ACADEMY OF MEDICINE

(F. C. Clifford, M.D., Secretary)

January 4—Annual dinner. Installation of new president, Dr. T. L. Ramsey. Election of the following officers: President-elect, Dr. L. R. Carr; secretary, Dr. F. C. Clifford; member of board of trustees, Dr. M. D. Haag, retiring president; member of the council, Dr. A. P. Hancuff, retiring secretary. Adoption of resolution opposing the erection of a new county tuberculosis hospital.

January 11—Section of Pathology, Experimental Medicine and Bacteriology. Program: "Clinical and Pathological Recognition of Some of the Common Diseases of the Skin", Dr. A. P. R. James.

January 18 — Medical Section. Program: "Status Thymico-Lymphaticus", Dr. F. W. Morley; discussants, Dr. L. E. Payne, Dr. C. E. Hufford, and Dr. Bernard Steinberg.

January 25—Surgical Section. Program: "The Early Diagnosis and Treatment of Appendicitis", Dr. R. H. Elrod; discussant, Dr. William A. Neill.

Defiance County Medical Society at its meeting December 17 elected the following officers: President, Dr. P. E. Newcomb, Defiance; vice president, Dr. D. J. Slosser, Defiance; secretary-treasurer, Dr. H. B. Wideman, Defiance; legislative committeeman, Dr. W. E. McKee, Ney; medical defense committeeman, Dr. McKee; delegate, Dr. Slosser; alternate, Dr. Newcomb.—D. J. Slosser, M.D., retiring secretary.

Henry County Medical Society held its annual meeting December 18. Following dinner, Dr. Thomas Quinn, Napoleon, addressed the Society on "Osteomyelitis". The following officers were elected: President, Dr. C. G. Hissong, Hamler; vice president, Dr. C. B. Geiger, Holgate; secretary-treasurer, Dr. F. M. Harrison, Napoleon; legislative and medical defense committeeman, Dr. J. R. Bolles, Napoleon; delegate, Dr. Thomas Quinn, Napoleon; alternate, Dr. T. P. Delventhal, Napoleon.—F. M. Harrison, M.D., Secretary.

Putnam County Medical Society has elected the following officers for the ensuing year: President, Dr. C. W. Bird, Continental; vice president, Dr.

J. R. Echelbarger, Ottawa; secretary-treasurer, Dr. L. M. Piatt, Ottawa; correspondent, Dr. W. B. Light, Ottawa; legislative committeemen, Dr. B. E. Watterson, Dr. C. O. Beardsley and Dr. W. D. Hickey, of Continental, Ottawa and Leipsic, respectively; medical defense committeemen, Dr. P. D. Bixel, Pandora, Dr. W. B. Recker, Leipsic, and Dr. A. H. Trumbull, Columbus Grove; delegate, Dr. A. L. Fipp, Glandorf; alternate, Dr. H. A. Lewis, Continental.—W. B. Light, M.D., retiring secretary.

Sandusky County Medical Society, in session December 27, elected officers for the ensuing year as follows: President, Dr. A. F. Schultz, Fremont; vice president, Dr. J. L. Curtin, Fremont; secretary-treasurer, Dr. Carl J. Wolf, Fremont; legislative committeeman, Dr. M. M. Riddell, Fremont; medical defense committeeman, Dr. H. K. Shumaker, Bellevue; delegate, Dr. Charles R. Pontius, Fremont; alternate, Dr. C. L. Smith, Fremont. The program was presented by Dr. Schultz, who spoke on "Osteomyelitis", and Dr. E. M. Ickes, Fremont, who discussed "Hypothyroidism and Phlebitis".—News Clipping.

Wood County Medical Society held a dinner meeting December 20 at the Bowling Green Women's Club. The guest speaker was Dr. H. F. Howe, Toledo, who discussed "Colitis and Its Treatment". At the business session, the following officers were elected: President, Dr. F. L. Sterling, Bowling Green; vice president, Dr. C. S. Cavett, North Baltimore; secretary-treasurer, Dr. R. N. Whitehead, Bowling Green; correspondent, Dr. H. J. Powell, Bowling Green; legislative committeeman, Dr. Daniel R. Barr, Grand Rapids; medical defense committeeman, Dr. W. H. Rheinfrank, Perrysburg; delegate, Dr. F. V. Boyle, Bowling Green; alternate, Dr. Paul F. Orr, Perrysburg.—R. N. Whitehead, M.D., Secretary.

Fifth District

CLEVELAND ACADEMY OF MEDICINE

(J. A. Garvin, M.D., Secretary)

The following officers for 1935 have been elected by the Cleveland Academy of Medicine: President, Dr. Lester Taylor; vice president, Dr. D. M. Glover; secretary-treasurer, Dr. J. A. Garvin; correspondent, Dr. Joseph T. Smith; legislative committeeman, Dr. F. S. Gibson; directors, Drs. R. S. Dinsmore, C. H. Heyman, H. C. King, H. V. Paryzek, and H. L. Rockwood.

Meetings of the Academy held during January were as follows:

January 4—Clinical and Pathological Section. Program: "Case of Hypertrophy of the Pylorus in An Adult", Dr. J. L. Kocour; "Resection of Presacral Nerve for Dysmenorrhea", Dr. E. A. Mastics; "A Case of Peri-arteritis Nodosum Associated with Asthma and Raynaud's Disease", Dr. H. V. Paryzek; "Ruptured Thoracic Aneurysm", Dr. A. E. Szcztkowski and Dr. H. Sneiderman; "A Case of Recto-Vaginal Fistula, with Megacolon", Dr. F. A. Spittler; "Technic of Radium Treatment of the Cervix", Dr. L. A. Pomeroy.

January 7—Pediatric Section. Program: "Psychiatry in the Care of Children", Dr. Frank G. Ebaugh, professor of psychiatry, University of Colorado Medical School.

January 11—Joint Meeting of Experimental Medicine Section and Cleveland Section of the Society for Experimental Biology and Medicine. Program: "Erythrocyte Shape and Hemolysis in Hypotonic", Dr. Russell Haden; "Two Methods for the Detection of Extremely Small Quantities of Ultraviolet Radiation and Some Practical Applications", Otto Glasser, Ph.D.; "Dietary Factors Which Influence the Formation and Dissolution of Renal Calculi", Dr. Charles Higgins; "Some Physiologic Properties of the Hormone Inhibin", D. Roy McCullagh, Ph.D., Eugene Cutuly, Ph.D., and Christina Deeton; "Observations on a Case of Paroxysmal Hemoglobinuria", Dr. A. Carlton Ernstene and Dr. W. James Gardner; "Some Clinical Observations Using Blood Iodine Determinations", Dr. E. Perry McCullagh and D. Roy McCullagh, Ph.D.; "Mechanism of Symptom Production in Allergic Asthma", Dr. M. B. Cohen.

Erie County Medical Society in session December 27 elected the following officers: President, Dr. Lyle S. Hill, Sandusky; vice president, Dr. John A. Yochem; secretary-treasurer, Dr. Ross M. Knoble. Four physicians were elected to membership, namely: Drs. Charles Reichenbach, Wayne Brown, J. C. Longnecker and V. J. Killoran.—Ross N. Knoble, M.D., Secretary.

Lake County Medical Society held its annual election of officers on December 18 at Lake County Memorial Hospital, Painesville. Those elected were: President, Dr. C. H. Browning, Painesville; vice president, Dr. E. L. Haffner, Fairport; secretary-treasurer, Dr. Mabel L. Pearce, Painesville; legislative committeeman, Dr. W. P. Ellis, Painesville; medical defense committeeman, Dr. J. V. Winans, Madison; delegate, Dr. V. N. Marsh, Painesville; alternate, Dr. R. E. Gardner, Mentor.—Mabel L. Pearce, M.D., Secretary.

Lorain County Medical Society met January 8 at the Lorain Hotel. New officers were installed and an interesting paper on "Physiotherapy" was read by Dr. George D. Nicholas, Elyria.—News Clipping.

Trumbull County Medical Society has elected Dr. Moses Knappenberger, Warren, president, and Dr. A. H. Seiple, Warren, secretary-treasurer, for the ensuing year.

Sixth District

The 230th session of the Union Medical Association, comprising the county societies of the Sixth Councilor District, was held January 9 at the

Mayflower Hotel, Akron. The afternoon's scientific program was presented by Dr. F. C. Hendrickson, Canton; Dr. C. E. Jelm, Akron, and Dr. William N. Taylor, Columbus. Dr. Hendrickson spoke on "Urological Examination of Children; Dr. Jelm on "The *X*-ray and Its Bearing on Urological Diagnosis" and Dr. Taylor on "The Evaluation of Urology in Medicine". Following a banquet in the evening, arranged by Dr. H. S. Davidson, councilor of the Sixth District, Dr. A. S. McCormick, and Dr. H. V. Sharp, the association met jointly with the Summit County Medical Society. The following program on "The Progress of 1934" was presented by Akron physicians: "Urology", Dr. I. L. Houghton; "Eye, Ear, Nose and Throat", Dr. C. R. Anderson; "Pediatrics", Dr. N. Miller; "Medicine", Dr. K. D. Way, and "Surgery", Dr. A. F. Dorner. The banquet speaker was Chester G. Wise, Akron, attorney. During the business session of the association, the following officers were elected: President, Dr. R. S. Friedley, and secretary, Dr. K. H. Harrington, both of Akron. Dr. Harrington succeeds Dr. J. H. Seiler, Akron, who had served for 47 years as secretary-treasurer of the association. It was voted to hold a meeting in April at Canton.

Ashland County Medical Society met in regular session and dinner on January 11. Dr. C. B. Meuser, Ashland, made an interesting talk on "Early Versus Late Forceps". Dr. E. L. Clem, Ashland, discussed "The Forceps on the After-coming Head". An instrument similar to one blade of a forceps which his grandfather had used in 1850 was displayed by Dr. G. B. Fuller, Londonville. The following committees were appointed: Legislative committeeman, Dr. C. B. Meuser, Ashland; medical defense committeeman, Dr. George Riebel, Ashland; economics committee, Dr. E. L. Clem, Ashland, Dr. M. J. Thomas, Jeromesville, and Dr. J. M. Heyde, Loudonville.—M. J. Thomas, M.D., Secretary.

Mahoning County Medical Society held its annual meeting at the Youngstown Club on December 18. Dr. James L. Fisher was installed as president for the ensuing year and the following additional officers elected: President-elect, Dr. L. G. Coe; vice president, Dr. P. J. Fuzy; secretary, Dr. William M. Skipp; treasurer, Dr. Louis Deitchman; correspondent, Dr. P. J. Harvey; legislative committeeman, Dr. O. J. Walker; medical defense committeeman, Dr. D. H. Smeltzer; delegates, Dr. Sidney McCurdy, Dr. C. B. Norris; alternates, Dr. W. K. Stewart, Dr. W. X. Taylor.

The annual banquet of the society was held on January 17 with Dr. George H. Hendon, professor of surgery, University of Louisville, as the guest speaker.—Bulletin.

Portage County Medical Society met in regular session January 3 at Robinson Memorial Hospital, Ravenna. James Allen, director of relief of Portage County, was presented and explained matters pertaining to physical examination of women employed at relief stations. The members protested the inadequate fee of $1.00 allowed physicians for making the examinations but finally voted to cooperate with the relief administration. Dr. C. C. Higgins, Cleveland, presented an illustrated lecture on "Experimental Production of Kidney and Bladder Stones and the Solution and Prevention of Urinary Calculi in Patients by Following Special Diets". Copies of the Constitution and By-Laws published in booklet form, together with names of the members and dates of their admission, were distributed.—E. J. Widdecombe, M.D., Secrtary.

Richland County Medical Society has elected the following officers for 1935; President, Dr. B. E. Shreffler, Mansfield; vice president, Dr. D. A. Weir, Mansfield; secretary-treasurer, Dr. H. C. Winbigler, Mansfield; legislative committeeman, Dr. Charles R. Keller, Mansfield; medical defense committeeman, Dr. W. E. Wygant, Mansfield; delegate, Dr. S. C. Schiller, Mansfield; alternate, Dr. W. D. Abrams, Mansfield.—H. C. Winbigler, M.D., Secretary.

Summit County Medical Society at its annual meeting installed Dr. J. D. Smith as president and elected the following officers: President-elect, Dr. F. B. Roberts; secretary-treasurer, Dr. A. S. McCormick (21st term); legislative committeemen, Dr. J. H. Weber and Dr. A. H. Franks; delegates, Dr. F. C. Potter, Dr. C. R. Steinke and Dr. D. B. Lowe; alternates, Dr. S. E. McMaster, Dr. J. E. Springer, and Dr. W. A. Hoyt.—A. S. McCormick, M.D., Secretary.

Stark County Medical Society had as its guest speaker on January 15, Dr. Hugh G. Beatty, Columbus, who spoke on "The Pharyngeal Lymphatics and the Indication for Tonsil-Adenoid Operation". The discussion which followed was opened by Dr. M. E. Scott and J. R. Brandon.—Bulletin.

Seventh District

Coshocton County Medical Society has elected the following officers for the ensuing year: President, Dr. C. M. Neldon, Coshocton; vice president, Dr. J. C. Briner, West Lafayette; secretary-treasurer, Dr. J. D. Lower, Coshocton; legislative committeeman, Dr. E. M. Wright, Coshocton; medical defense committeeman, Dr. Wright; delegate, Dr. Floyd Craig, Coshocton; alternate, Dr. Samuel Kistler, Coshocton.—J. D. Lower, M.D., Secretary.

Tuscarawas County Medical Society met in regular session January 10 at Dover City Hall. The program consisted of a discussion of scarlet fever, based on a study outline on this subject published in the *Ohio State Medical Journal*. Dr. G. L. Sackett led the general discussion with a paper on the general aspects of scarlet fever; Dr. M. W. Everhart spoke on the otorhinological complica-

tions of scarlet fever; and Drs. Downey, Syler, Roche and Blickensderfer took part in the discussion which followed the papers.—Bulletin.

Eighth District

Athens County Medical Society met January 7 at Athens. Dr. M. N. Fowler discussed a case of undulant fever treated successfully at the Athens State Hospital. A turkey dinner was served. Dr. C. S. Small was elected to membership.—T. A. Copeland, M.D., Secretary.

Fairfield County Medical Society has elected the following officers for 1935: President, Dr. K. W. Taylor, Pickerington; vice president, Dr. F. W. James, Lancaster; secretary-treasurer, Dr. C. W. Brown, Lancaster; legislative committeeman, Dr. C. G. Axline, Lancaster; medical defense committeeman, Dr. B. H. Biddle, Sugar Grove; delegate, Dr. Ralph Smith, Lancaster; alternate, Dr. C. H. Hamilton, Lancaster.—C. W. Brown, M.D., Secretary.

Guernsey County Medical Society held its annual turkey dinner on December 20 at the Berwick Hotel. Wives of the members were guests. Following the dinner an interesting illustrated address on "The Palestine" was made by Dr. Robert N. Montgomery, president of Muskingum College.

On January 3 the society was addressed by Dr. H. H. McClellan, Dayton. Following the address the 1935 officers were installed.—O. R. Jones, M.D., Secretary.

Muskingum County—Annual meeting and banquet of the Muskingum Academy of Medicine were held December 13 at the Zanesville Golf Club. At the business session, the following officers were elected: President, Dr. W. D. Coffman; vice president, Dr. H. T. Glaser; secretary-treasurer, Dr. Beatrice T. Hagen; censor, Dr. D. G. Caudy; member of policy committee, Dr. R. B. Bainter. On January 9, the academy met at the University Club. The meeting was devoted to a general discussion of socialized medicine.—Beatrice T. Hagen, M.D., Secretary.

Perry County Medical Society has elected the following officers for the ensuing year: President, Dr. C. B. McDougal, New Lexington; vice president, Dr. H. F. Minshull, New Lexington; secretary-treasurer, Dr. F. J. Crosbie, New Lexington; legislative committeeman, Dr. R. W. Miller, New Lexington; medical defense committeeman, Dr. J. H. Clouse, Somerset; delegate, Dr. James Mille Corning; alternate, Dr. J. G. McDougal, New Lexington.—F. J. Crosbie, M.D., Secretary.

Washington County Medical Society held annual meeting December 12 at Memorial Hospital, Marietta. The following officers were elected: President, Dr. A. Howard Smith, Marietta; vice president, Dr. Charles C. Deamude, Waterford; secretary-treasurer, Dr. R. M. Meredith, Marietta; legislative committeeman, Dr. S. A. Cunningham, Marietta; medical defense committeeman, Dr. G. M. James, Marietta; delegate, Dr. W. W. Sauer, Marietta; alternate, Dr. S. E. Edwards, Marietta.—R. M. Meredith, M.D., Secretary.

Ninth District

Hocking County Medical Society in regular session elected the following officers for the ensuing year: President, Dr. J. L. Webb, Carbon Hill; vice president, Dr. Allan A. Cole, Logan; secretary-treasurer, Dr. M. H. Cherrington, Logan; delegate, Dr. C. F. Shonk, Logan; alternate, Dr. W. B. Lacock, Logan. On January 10 the society adopted a resolution approving the present city-county public health set-up and protesting action of the City Council at Logan in withdrawing the city from the present arrangement. Dr. J. L. Webb discussed a case of glandular disease.—News Clipping.

Jackson County Medical Society at its annual meeting elected the following officers: President, Dr. J. S. Hunter, Jackson; secretary-treasurer, Dr. J. J. McClung, Jackson; legislative committeeman, Dr. W. R. Evans, Jackson; medical defense committeeman, Dr. E. T. Dando, Wellston; delegate, Dr. A. G. Ray, Jackson; alternate, Dr. J. L. Frazer, Wellston.—J. J. McClung, M.D., Secretary.

Lawrence County Medical Society has elected the following officers for 1935: President, Dr. Ralph F. Massie, Ironton; vice president, Dr. Charles E. Vidt, Ironton; secretary-treasurer, Dr. W. Wilson Lynd, Ironton; legislative and medical defense committeeman, Dr. E. E. Ellsworth, Ironton; delegate, Dr. G. G. Hunter, Ironton; alternate, Dr. Cosper Burton, Ironton.—Anne D. Marting, M.D., retiring secretary.

Meigs County Medical Society at its annual meeting elected the following officers: President, Dr. H. M. Crumley, Pomeroy; vice president, Dr. F. M. Cluff, Middleport; secretary-treasurer, Dr. R. E. Boice, Middleport; legislative committeeman, Dr. Boice; medical defense committeeman, Dr. Cluff; delegate, Dr. Boice; alternate, Dr. Cluff.—R. F. Boice, M.D., Secretary.

Pike County Medical Society has elected the following officers for the ensuing year: President, Dr. L. E. Wills, Waverly; vice president, Dr. P. H. Jones, Stockdale; secretary-treasurer, Dr. Robert T. Leever, Waverly; medical defense committeeman, Dr. I. P. Seiler, Piketon; delegate, Dr. R. M. Andre, Waverly; alternate, Dr. W. L. McCaleb, Beaver.—R. T. Leever, M.D., Secretary.

Scioto County—The Hempstead Academy of Medicine met in regular session January 4. A symposium on "Unusual Experiences in Obstetrics" was presented by Drs. J. S. Rardin, H. A. Schirrmann and A. R. Moore.—Bulletin.

Tenth District

COLUMBUS ACADEMY OF MEDICINE
(Drew L. Davies, M.D., Secretary)

January 7—Annual Meeting. Reports of officers and committees. Installation of the following officers: President, Dr. E. G. Horton; vice president, Dr. H. E. LeFever; secretary-treasurer, Dr. Drew L. Davies; legislative committeeman, Dr. John M. Thomas; medical defense committeeman, Dr. J. F. Baldwin; delegates, Drs. John M. Thomas, J. B. Alcorn, E. J. Emerick, I. B. Harris and J. H. J. Upham; alternates, Drs. E. J. Stedem, George T. Harding, Drew L. Davies, J. H. Warren, and H. E. LeFever. Program: "Progress in Medicine", Dr. E. F. McCampbell; "Progress in Obstetrics", Dr. C. W. Pavey.

January 14—General Session. Program: "Progress in Surgery", Dr. P. J. Reel; "Progress in Pediatrics", Dr. Earl Baxter.

Crawford County Medical Society met on January 7 at the Bucyrus City Hospital. The guest speakers were Dr. Frank W. Harrah and Dr. J. W. Warren, both of Columbus. Dr. Harrah spoke on "*X*-ray Diagnosis of Urological Pathology", and Dr. Warren on "Diagnosis of Gastric Pathology".—Bulletin.

Knox County Medical Society has elected the following officers for 1935: President, Dr. E. V. Ackerman, Fredericktown; vice president, Dr. C. L. Harmer, Danville; secretary-treasurer, Dr. Robert L. Eastman, Mt. Vernon; legislative committeeman, Dr. John P. Claypool, Mt. Vernon; delegate, Dr. F. C. Anderson, Mt. Vernon; alternate, Dr. Julius Shamansky, Mt. Vernon.—Robert L. Eastman, M.D., Secretary.

Madison County Medical Society has elected the following officers for the ensuing year: President, Dr. R. W. E. Irwin, Mt. Sterling; vice president, Dr. W. A. Holman, London; secretary-treasurer, Dr. F. A. Lutz, Mt. Sterling; legislative committeeman, Dr. Holman; medical defense committeeman, Dr. R. H. Trimble, Mt. Sterling; delegate, Dr. G. C. Schoetz, West Jefferson; alternate, Dr. [illegible] Secre-

Ross County Medical Society was addressed on January 3 by Dr. Charles Turner and Dr. George P. Sims, Columbus. Dr. Turner spoke on "Caesarean Section", and Dr. Sims on "*X*-ray Treatment of Goiter". The following officers were elected: President, Dr. O. P. Tatman, Chillicothe; vice president, Dr. L. E. Hoyt, Chillicothe; secretary-treasurer, Dr. W. C. Breth, Chillicothe; legislative committeeman, Dr. H. R. Brown, Chillicothe; medical defense committeeman, Dr. L. T. Franklin, Chillicothe; delegate, Dr. A. E. Merkle, Chillicothe; alternate, Dr. W. B. Smith, Frankfort.—W. C. Breth, M.D., secretary.

Union County Medical Society in session December 11 elected the following officers: President, Dr. P. D. Longbrake, Marysville; vice president, Dr. R. H. Martin, Magnetic Springs; secretary-treasurer, Dr. H. E. Stricker, Marysville.

—OSMJ—

Modified Regulations on "Supply Order" for Medical Services to Needy Patients

Pursuant to a complaint filed by the State Medical Association, the comptroller and auditor of the State Relief Commission has modified the regulations requiring all relief clients to sign relief supply orders issued in their favor in cases where the relief supply order is issued to a person for the services of a physician.

The new procedure regarding relief supply orders issued for medical services is as follows:

Where a physician is authorized to make only one call on a person on the relief rolls, the relief supply order should be filled out by the County Relief Director and sent direct to the physician. The physician should return the relief supply order, together with his medical report, to the office of the County Relief Administration. The signature of the patient to the supply order will *not* be necessary. Where the physician is authorized to make *more* than one call to the patient, the patient will be required to sign the relief supply order, such signature being obtained by the physician at the time of the second call.

In explaining this new procedure, Jay L. hambers, comptroller and auditor of the State elief Commission, stated that the relief supply rder should be made out by the County Relief)irector and mailed to the physician as soon as he authorization for medical service has been nade. If this is done, Mr. Chambers said, the)hysician will have the supply order in time to btain the patient's signature when making his econd or subsequent call on the patient.

If there is delay in getting the relief supply)rder to the physician, Mr. Chambers is of the)pinion the County Relief Director should not adhere too strictly to the requirement that such orders must be signed by the patient on the physician's second visit.

It was pointed out to the State Relief Commis-

sion that the previous regulation, made at the request of the Field Examiner for the FERA, was impracticable and an unjust burden on the physician, inasmuch as frequently the relief supply order is not in the hands of the physician at the time he visits the patient the first time and to obtain the patient's signature he would be required to make a socond call for which, if the call was unauthorized, he received no fee.

Mr. Chambers stated that the requirement was established to reduce to a minimum the unscrupulous person who may want to prey upon relief clients and to enable the client to know exactly what he was getting.

However, he admitted the regulation was not practicable in the case of medical services and subsequently modified the requirement as described previously.

Physicians attending persons on relief should insist that their local Relief Director furnish them promptly with a relief supply order in every case so that the requirement of having the patient sign the order at the time of the second visit can be complied with.

Deaths in Ohio

Archibold N. Dawson, M.D., Lakewood; Western Reserve University, School of Medicine, 1908; aged 52; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died December 20 of a brain tumor. Dr. Dawson was chief obstetrician at Lakewood Hospital. Surviving are his widow, two sons, one daughter, his mother, two brothers and one sister.

Howard M. Fenton, M.D., Shaker Heights; Western Reserve University, School of Medicine, 1878; aged 85; died December 15 of pneumoı Dr. Fenton practiced for 16 years at Troy bef moving to Cleveland. His widow and one dau ter survive.

Wilson D. Forsythe, M.D., New Concord; St ling Medical College, Columbus, 1891; aged member of the Ohio State Medical Association the American Medical Association; died Janu 12. Dr. Forsythe has practiced at Rix Mills fore moving to New Concord 22 years ago. S viving are three daughters, one sister and brother.

Eugene J. Gregg, M.D., Cleveland; Meha Medical College, 1905; aged 56; died Januar of a lung infection. His widow, his mother one sister survive.

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Medical College, Cincinnati, 1900; age 68; died December 30. One sister survives.

James T. Mills, M.D., Gilmore; Columbus Medical College, 1881; aged 82; died January 2. Dr. Mills practiced for 50 years at Gnadenhutten before moving to Gilmore. Two daughters survive.

E. Otis Smith, M.D., Cincinnati; Medical College of Ohio, 1896; aged 63; member of the Ohio State Medical Association and Fellow of the American Medical Association; died December 26 of heart disease. Until two years ago when his health failed, Dr. Smith had been for 25 years professor of urology at the University of Cincinnati. He held the chair of professor emeritus at the time of his death. Dr. Smith began the practice of medicine in Cincinnati 38 years ago. During the World War, Dr. Smith was regional health director for the United States Army for the Central States. In 1917, Dr. Smith was elected president of the Ohio State Medical Association, holding that office for two years. For the past number of years, he had been a member of the Committee on Medical Economics and had been for many years an active member of the House of Delegates of the State Medical Association. Dr. Smith was formerly chief of staff of Good Samaritan Hospital, Cincinnati, and member of the staffs of General Jewish and Bethesda hospitals. He was former secretary of the Cincinnati Academy of Medicine; a Fellow of the American College of Surgeons; member of the American Urological Association; chief medical director of the Federal Union Life Insurance Company; member of Phi Kappa Psi and Nu Sigma Nu fraternities; former president of the Cincinnati University Alumni Association; member of the Cincinnati Club, Rotary Club, Maketewah Country Club and the Mt. Auburn Methodist Episcopal Church. His widow, one son and two daughters survive.

John P. Sobey, M.D., Western College of Homeopathy, Cleveland; aged 84; died January 9 of pneumonia. He retired from practice a number of years ago to open a pharmacy.

Roy G. Strong, M.D., Medina; University of Buffalo, School of Medicine, 1901; aged 56; died December 12 of heart disease. Dr. Strong had practiced in Medina for 25 years. He served overseas during the World War, holding the rank of lieutenant in the medical corps. Surviving are his widow and one son.

J. E. Campbell Taylor, M.D., Columbus; Ohio State University, College of Medicine, 1928; aged 35; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died December 12 of influenza. Dr. Taylor was the grandson of the late Governor James E. Campbell and a lifelong resident of Columbus. He had practiced in Columbus since completing his internship at Kings' County Hospital, Brook-

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lyn, and the Mayo Clinic. He was a member of the Alpha Kappa Kappa Fraternity. Surviving are his widow, one son, two daughters, and his father.

John A. Thompson, M.D., McComb; Cleveland University of Medicine and Surgery, 1881; aged 86; died December 28 of infirmities of age. Dr. Thompson had been a resident of Hancock County for 65 years. A step-son and half brother survive.

Emma Underwood, M.D., Springfield; Indianapolis Medical School, 1895; aged 88; died December 11. Dr. Underwood was a native of London, England, and had lived in Springfield many years.

Joseph A. Weitz, M.D., Montpelier; University of Michigan Medical School, 1886; aged 86; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died January 11 of heart disease. Dr. Weitz was a former president of the Williams County Medical Society and for many years secretary of the society. Also he was a former health commissioner and member of the board of education. Dr. Weitz belonged to the Masonic Lodge and Presbyterian Church. Surviving are his widow and one daughter.

KNOWN IN OHIO

Edward R. Perry, M.D., Tacoma, Washington, formerly of Ripley; Medical College of Ohio, Cincinnati, 1896; aged 62; died December 20. His widow, his mother and one brother, Dr. Frank Perry, Norwood, survive.

Lewis A. Williams, M.D., Huntington, West Virginia, formerly of Miller, Lawrence County; Medical College of Ohio, Cincinnati, 1891; aged 70; died December 27. Dr. Williams had lived in Huntington for the past 20 years. His widow, two sons, one daughter, one brother and two sisters survive.

—OSMJ—

Attorney General Rules On Site for T. B. Hospital

There is no statutory provision preventing the keeping of a person afflicted with pulmonary tuberculosis in a building constructed on property which is immediately adjacent to a county home, Attorney General John W. Bricker has ruled (Opinion No. 3625) in answer to an inquiry from the State Department of Health which had been asked by a board of county commissioners to consent to the building of a tuberculosis hospital on land adjacent to the main building of the county home under the commissioners' supervision.

Mr. Bricker pointed out if such proposed tuberculosis hospital is not actually a part of, or connected with, the county home in such manner as to permit those afflicted with pulmonary tuber-

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culosis associating with the occupants of the home; and the hospital is maintained as a separate and distinct institution, especially as to laundry and kitchen, he is unable to find any legal impediment to the location of the hospital adjacent to the county home.

However, he emphasized that the statutes grant broad powers to the county commissioners and the State Department of Health in determining the necessity, style, dimensions and location of a tuberculosis hospital.

Under such powers, Mr. Bricker said, the county commissioners and State Department of Health must determine whether the keeping of a person suffering from tuberculosis in a building immediately adjacent to a county home is or is not contrary to sound principles of public health, especially those setting up safeguards to protect the inmates of the county home from exposure and contact with persons afflicted with tuberculosis.

NEWS NOTES of OHIO

Cleveland—Cleveland City Council's welfare committee has approved the consolidation of all the public health services of Cuyahoga County with the Cleveland Health Department, as a part of the borough plan movement now underway in that county.

Toledo—Dr. M. R. Kukuk has been appointed health commissioner of Lucas County, succeeding the late Dr. Fred DeVore.

Cedarville—Dr. Donald F. Kyle, formerly of Columbus, has become an associate of Dr. M. I. Marsh in practice here.

Columbus—New officers of the Section on General Medicine, Columbus Academy of Medicine, are: Dr. C. H. Wells, president; Dr. Paul S. Ross, secretary; Dr. A. A. Hall, Dr. John Rauschkolb and Dr. L. M. Harris, members of executive committee.

McConnellsville—Dr. Arnold Abraham has moved to Niles, Michigan.

Massillon—Dr. Charles A. Bogue, formerly of Warren, has been appointed to the medical staff at the Massillon State Hospital.

Steubenville—Dr. F. B. Harrington has resigned as medical director at the Weirton Steel Company to engage in private practice. His successor is Dr. L. A. Whitaker.

Ironton—The Lawrence County Medical Society has selected a committee of four to take part in the campaign for the proposed city-county hospital here. Those on the committee are: Dr. O. H. Henninger, Dr. W. F. Marting, Dr. C. E. Vidt and Dr. Chester A. Casey.

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AS A MEDIUM OF SERVICE TO ITS MEMBERS

MARCH 1, 1935 VOL. XXXI Number 3

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Ohio State Medical Journal

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Athens	W. E. Howe, Nelsonville	T. A. Copeland, Athens	1st Monday, monthly.
Fairfield	K. W. Taylor, Pickerington	C. W. Brown, Lancaster	2d Tuesday, monthly.
Guernsey	C. A. Craig, Cambridge	Reo Swan, Cambridge	1st and 3rd Thursday each month.
Licking	Geraldine Crocker, Granville	G. A. Gressle, Newark	Last Friday, monthly.
Morgan	D. G. Ralston, McConnelsville	C. E. Northrup, McConnelsville	3rd Tuesday, monthly.
Muskingum	W. D. Coffman, Zanesville	Beatrice T. Hagen, Zanesville	1st Wednesday, monthly.
Noble			
Perry	C. B. McDougal, New Lexington	F. J. Crosbie, New Lexington	3d Monday, monthly.
Washington	A. H. Smith, Marietta	R. M. Meredith, Marietta	2d Wednesday, monthly.
Ninth District			
Gallia	E. G. Lupton, Gallipolis	Milo Wilson, Gallipolis	1st Wed., Feb., May, Sept. and Dec.
Hocking	J. L. Webb, Nelsonville	M. H. Cherrington, Logan	2nd Thursday, monthly.
Jackson	J. S. Hunter, Jackson	J. J. McClung, Jackson	2nd Tuesday, monthly.
Lawrence	R. F. Massie, Ironton	W. W. Lynd, Ironton	1st Thursday, monthly.
Meigs	H. M. Crumley, Pomeroy	R. E. Boice, Middleport	3d Thursday, bi-monthly.
Pike	L. E. Wills, Waverly	R. T. Leever, Waverly	1st Monday, monthly.
Scioto	R. P. Elder, Portsmouth	Wm. E. Scaggs, Portsmouth	2d Monday, monthly.
Vinton	O. S. Cox, McArthur	H. D. Chamberlain, McArthur	3d Wednesday, monthly.
Tenth District			
Crawford	M. L. Helfrich, Galion	C. J. Griebling, Galion	1st Monday, monthly.
Delaware	J. K. James, Delaware	W. E. Borden, Delaware	1st Tuesday, monthly.
Franklin	E. G. Horton, Columbus	Drew Davies, Columbus	1st four Mondays, monthly.
Knox	E. V. Ackerman, Fredericktown	R. L. Eastman, Mt. Vernon	Last Thursday, monthly.
Madison	R. W. E. Irwin, Mt. Sterling	F. A. Lutz, Mt. Sterling	4th Wednesday, monthly.
Morrow	C. E. Sherman, Cardington	T. Caris, Mt. Gilead	Last Thursday, monthly.
Pickaway	R. S. Hosler, Ashville	E. R. Austin, Circleville	1st Friday, monthly.
Ross	O. P. Tatman, Chillicothe	W. C. Breth. Chillicothe	1st Thursday, monthly.
Union	P. D. Longbrake, Marysville	H. E. Stricker, Marysville	2d Tuesday, monthly.



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PUBLIC HEALTH - SOCIAL WELFARE MEDICAL ECONOMICS and ORGANIZATION PROBLEMS

With Editorial Comment by D.K.M.

To repeat what has been said on numerous occasions in these columns, the medical profession cannot hope to cope successfully with the complicated and serious questions confronting it unless physicians are accurately and adequately informed on trends and developments bearing on the questions affecting medical practice, directly or indirectly.

Contacts In Organization

One of the fundamental purposes of medical organization is to disseminate information relating to numerous aspects of medical practice. This is accompulished in several different ways: first, through the publication of *The Journal;* second, through the issuance at regular intervals of bulletins to the secretaries of the component county medical societies and academies of medicine by the State Headquarters Office; third, through frequent bulletins issued by the Committee on Public Policy to the local legislative committeemen, summarizing legislative and governmental developments and policies relating to them, and suggesting local activity for or against such questions which affect public health, scientific medicine and medical practice.

It is assumed that most physicians affiliated with medical organization keep themselves informed by reading *The Journal,* in every issue of which is published news and comment relative to important matters of direct interest to the medical profession. Physicians who have not taken advantage of this opportunity to keep themselves posted on current medical events should resolve to do so. In this day of numerous and rapid economic and social changes, a physician can soon lose step with his colleagues unless he knows what is going on and what is expected of him in the activities of organized medicine.

The supplementary bulletins issued by the Headquarters Office to the local secretaries are of vital importance. They should be read at the first meeting of the local society or academy following their receipt for the information of members on matters relating to organization activities and new developments on questions previously commented on in *The Journal* or earlier secretaries' bulletins. The membership of each society should insist that these bulletins be submitted to them for consideration and discussion.

At this particular time, bulletins issued frequently—as often as once a week—by the Committee on Public Policy are of the utmost importance. During a session of the State Legislature it is vital that the membership be promptly informed of all developments affecting public health and medicine so that proper local activity in contacting members of the Legislature and discussing with them the concerted medical viewpoint on legislative issues can be undertaken. While these legislative bulletins are issued primarily to keep local legislative committeemen in touch with events and developments at Columbus and suggest steps which may be taken locally to establish friendly relations with legislators and other public officials, they always contain information which is of interest to the membership as a whole and which should be transmitted to it by the local legislative committeeman at regular meetings of the local society or academy or otherwise. The local legislative committeeman cannot be expected to shoulder the entire burden of contacting and interviewing members of the Legislature. He needs the assistance and cooperation of all his colleagues. At the same time, he cannot expect much aid from his fellow physicians unless he passes on to them the information which he has and obtains the benefit of their opinions on the best methods of handling complicated situations which develop. It is suggested that a place on the program at every county society or academy meeting be reserved for discussion and comments on secretaries' and legislative bulletins and questions referred to in them or in *The Journal.*

Societies publishing a regular bulletin and some societies who use letters or postcards to announce meetings, frequently devote space to information, bulletins or announcements disseminated from the Headquarters Office and committees of the State Association. This has proven an effective way of emphasizing important news and obtaining the active interest of all members in local activities on state-wide problems.

Those in key positions in local medical societies must be the mouthpiece of the state organization in disseminating important information and unless they do their job well, concerted action cannot be maintained and the influence of medical organization as a whole will depreciate.

Legislation And Health Protection

Of more than casual interest is a recent decision rendered by Attorney General John W. Bricker upholding the right of a city council and/or a city board of health by ordinance or regulation, respectively, to require the inspection of animals to be slaughtered for food and the inspection of the carcasses thereof.

In the first instance, the opinion strongly supports the policy that the protection of public health is a fundamental responsibility of the police power of the state.

However, of special interest is the language used by the Attorney General in support of his arguments, to wit:

"Legislation designed to preserve and protect the public health falls directly within the police power of the state. In fact, public health is one of the most vital subjects for the exercise of police power. Public health is the very heart of public happiness. The constitutional guaranties of life, liberty and the pursuit of happiness is of little avail unless there be clearly implied therefrom the further guaranty of safeguard of the public health in order that life, liberty and the pursuit of happiness be made practical and plenary.

"Duties relating to the preservation of public health devolve principally upon the state as a sovereign power. The power to determine what laws are necessary to promote public health rests primarily with the General Assembly, therefore the General Assembly possesses general authority to pass such laws as it is believed will protect and preserve public health, and the power to make all such provisions as may be reasonable, necessary and appropriate for such purpose. The authority of the state to enact health measures and to delegate such powers to various state agencies, is no longer open to question."

Mr. Bricker's reference to the responsibility of the General Assembly in questions of public health is particularly timely. His statement that the Legislature "possesses the authority to pass such laws as it is believed will protect and preserve public health" implies also that the responsibility of seeing that present adequate public health safeguards are maintained, in other words that the Legislature must assume the responsibility for any and all detriments which might, and doubtless would, result from legislation weakening the existing public health laws and statutes regulating the practice of medicine. The Attorney General's view regarding the importance and necessity for protection of the public health through sound statutory provisions is a strong argument against the efforts constantly being made—especially now—by cultists, groups of limited practitioners and those with anti-medical and anti-health complexes to destroy or cripple existing health and medical laws.

The conflict between the conclusions reached by the Attorney General on the importance of public health administration and safeguards, and the viewpoints of the above mentioned groups is obvious. Which position is in the best interests of the public is quite apparent.

The Legislature will do well to follow the sound advice of Mr. Bricker and not tinker with what he has said is "the very heart of public happiness"—public health.

The Legislature's obligation—and every member should be made to realize this—is to guarantee the maintenance of public health safeguards by refusing to weaken the legal foundations for public health administration in Ohio and by refusing to modify the existing laws regulating the practice of the health arts in Ohio which require all desiring to practice to prove their qualifications and to practice in accordance with the rights and privileges to which they are entitled as measured by their training and fitness.

The enactment of any legislation which would cripple public health administration or destroy or invalidate the present laws governing the practice of medicine in any and all forms will be reactionary and prejudicial to the welfare of the public and handicap the state in effectively performing what Mr. Bricker has referred to as one of its most important and fundamental functions —protection of the public health.

— OSMJ —

Experiments In Group Medicine

All members of the State Association are respectfully urged to devote a part of their reading time to the article published on pages 215 to 218 of this issue of *The Journal* relating to the purposes and operation of the Detroit Medical Service Bureau, a plan established by the Detroit medical profession to assist the small-wage earner in meeting the costs of medical care.

The medical profession has been unjustly accused by some of its critics as being against any and all suggestions for changes in the present method of providing medical service for the public.

Yet, it is well known that in many parts of the country, the organized medical profession, frequently in cooperation with allied groups, has established, or is attempting to put into operation, programs under professional control to permit persons of modest means to obtain complete medical service from physicians of their own choice in a systematic way and at terms commensurate with the patient's financial status and ability to pay.

These experimental plans are being followed

with much interest and some one of them, or combination of several, may provide a solution to some of the difficulties which confront patients of moderate circumstances in event of sickness.

The so-called Detroit Plan has been referred to as one of the most interesting of these experiments in cooperative endeavor. The Wayne County Medical Society's plan has many interesting features. It is a comparatively simple arrangement whereby small-wage earners may obtain medical service from their own physicians, dentists, etc., and pay for the same on a pre-arranged time-payment basis.

The summary of the plan published in this issue should be studied carefully for, as stated previously, it may provide a partial solution to problems confronting physicians and patients of the low-income class in many communities of Ohio.

— OSMJ —

One Viewpoint On Compensation

At the risk of being convicted and penalized for heresy, treason or what have you, Dr. Beverly R. Tucker, writing in the *Virginia Medical Monthly*, boldly declares that "the physician is the best paid man in the world".

The deductions used by Dr. Tucker to arrive at this conclusion, especially intriguing at this particular time when the thoughts of most physicians are concerned with their material status and their pocketbook, if they are still fortunate enough to need one, are of more than casual interest.

Quoting from his comments:

"The physician is the best paid man in the world. He is required to have an education which will be a benefit and a comfort to him all the days of his life. He wins a degree and he attains the honorable title of doctor. He learns to know more intimately his fellow man than anyone else can know his fellow. He gets praise for many things that he does not deserve and providence and disease are blamed for his mistakes. He wins the gratitude of those he serves. His charity work is invaluable to his experience. If he is reasonably conscientious and works reasonably hard he builds a practice that will insure him a good house, office and automobile and enable him to rear and educate a family and to stand the losses of the inevitably foolish investments he makes. If he has taste for invention there are innumerable unknown instruments and improvements awaiting him. If he wishes to discover, the laboratory is ready for him. If he likes research the facilities and libraries are available. If he craves adventure insidious dangers lurk around him and there are ever pioneer fields to enter. In his endeavors his government, his community and his fellow physicians stand ready to aid him. He is an advocate without a jury, a judge without a court, a minister without a surplice, a business man without guile, a farmer whose soil is the human body and whose crops are human health and happiness and he is a laborer without a boss. The physician is the best paid man in the world."

It must be admitted that Dr. Tucker's observations are stimulating to thought on the part of all, some of whom, no doubt, have concluded that the practice of medicine is about the unhappiest vocation they could have chosen.

Medicine as a career may not offer all the advantages and opportunities, happiness and contentment which Dr. Tucker visualizes and he may be accused of having used rose-colored glasses in making his analysis.

Yet, it is probably a fact that few physicians would be willing to trade places with very many of those to whom they minister despite the trials and tribulations that have arisen to plague the medical profession in these trying times.

When considered from all angles, medicine as a career is second to none.

The challenge the medical profession faces now is how to maintain the high status in the field of medicine and medical practice.

Instead of worrying about the rigors and hardships exacted by the practice of medicine, the average physician may concern himself with how

Important Notice to Those Whose Dues Are Unpaid

IN compliance with Federal postal regulations, the names of all unpaid members of the State Medical Association must be removed from *The Journal* mailing list after this issue.

If you are among those on the "delinquent" membership list of the State Association, your membership dues for 1935 should be transmitted to the Secretary-Treasurer of your medical society or academy of medicine immediately.

Prompt payment of dues will insure the continuance of *The Journal*, as well as other organization benefits. It is of vital importance, especially during these times of rapid and radical social, economic and governmental changes and developments, many of which may have a direct and important bearing on the practice of medicine, that every eligible physician remain an active member of medical organization.

Membership dues for 1935 are due on or before January 1. As a courtesy to those who through neglect or oversight have thus far failed to pay their 1935 dues, *The Journal* has been mailed to them for the first three months of this calendar year. Only those whose dues are paid will receive future issues of *The Journal*, or be retained on the membership records.

to maintain medicine on a plane that will insure him advantages and opportunities equal at least to those he secured in more normal times ,which, as stated by Dr. Tucker, exceed those offered by most other professional and business endeavors.

— OSMJ —

Prominence of Psychiatry

In the period dating from the World War to the present time, the medical profession has made remarkable progress in dealing with the etiology and treatment of mental illness.

It is now appreciated among a large proportion of the medical profession that a sizeable number of patients encountered in the general practice of medicine present psychiatric problems. Psychotherapy is properly being recognized in the domain of scientific medicine, dealing with psychoneuroses and other forms of mental disorders, as well as the management of personality disorders, behavior problems and the problems of maladjusted individuals.

The development of these activities along sound medical lines is an important problem and one in which the medical profession as a whole should be deeply interested.

This particular question was the subject of lengthy discussion at the recent annual meeting of the American Psychiatric Association in New York City. In his presidential address, Dr. George H. Kirby reviewed some of the difficulties being encountered by psychiatrists in their efforts to put the handling of mental cases on a sound scientific basis.

"We have witnessed in recent years," Dr. Kirby declared, "an ever-increasing invasion in the field of psychotherapy by lay analysis, by psychologists with a smattering of analytic knowledge, by social service workers who have taken a course in analysis and various other persons poorly equipped and untrained yet confident that they were qualified for the serious and difficult task of attempting to treat sick persons by analytic methods.

"Professional psychologists and other groups of unqualified persons not only attempt to carry on clinical work and treatment of mental patients, but they do not hesitate to style themselves 'psychoanalysts' or 'psychiatrists'. The general public is confused as to where psychiatry belongs and tends to associate it less with medicine than with psychology.

"Medical schools and psychiatric hospitals are flooded with requests from non-medical persons who wish to take 'courses in psychiatry'. They fail to realize that psychiatry is a branch of medicine and cannot be safely practiced without a general medical training any more than can brain surgery or pediatrics.

Dr. Kirby believes that this condition can be remedied only through systematic public education and greater recognition on the part of medical education in the field of psychotheraphy. He adds that:

"The great body of physicians will never become sensitized to the significance of the psychiatric approach in medicine, or grasp the fundamentals of psychotherapy until more adequate provisions are made in the medical curriculum. . . . Psychiatry has an important role to play in this movement which will consider the sick person as well as the individual organs."

Many will agree with the prediction of Dr. Kirby that "medicine of the future will extend its interests, more and more, beyond the laboratory, the microscope, the test tube, and the individual organs of the person".

— OSMJ —

Future Doctors

Frequently, no doubt, every physician is asked by some youngster trying to make up his mind regarding the choice of a career, to express an opinion regarding the future and opportunities of medicine as a life pursuit.

With conditions as they are, the physician in all probability finds it somewhat difficult to reconcile his conflicting views on this question and give a frank answer to this inquiry.

However, we are inclined to agree with the slant taken by the writer of an editorial in a recent issue of *The Toledo Academy of Medicine Bulletin* which said in part:

"Whatever our feelings may be respecting the future of medicine, it is our belief that as long as there are young people who insist that a medical career is vital to their future happiness, we should not under any circumstances discourage them in their choice. **It is our contention that in advising such aspirants, both sides of the question should be discussed, and that the desirable features of medicine as a profession should have at least equal rank in importance with the undesirable.***

"If organized medicine is to carry on successfully in its battle to destroy the agencies which are encroaching upon its rights and privileges, then it must have new blood. The battle is just beginning and an early truce is not in prospect. Those of us who are actively engaged in fighting the medical economic battle must have followers whose hands are willing to seize the torch as it falls from ours. Who better can serve these ends than the youth who knocks at our threshold? Come what may to medicine, we have a duty to perform when our counsel is sought by one who would cast his lot among us. Let him see the unpleasant side if you will; but for his own future peace of mind as well as the good of medicine in general, do not dissuade him from following in your steps."

AMOEBIASIS

By CLAYTON C. PERRY, M.D.,

Cleveland, Ohio

NUMEROUS articles have appeared in the past few months on this important subject of amoebic dysentery. The recent epidemic in Chicago during 1933 and 1934 has emphasized the importance of this disease. Although it had long been known that this disease was not restricted to the tropical regions, it still was not regarded as a common ailment in the northern temperate zones.

Amoebiasis is a serious infection which should always be considered in any patient with intestinal upsets or other obscure conditions. Patients harboring the entamoebae do not always have diarrhea. The entamoeba histolytica is a tissue parasite whose portal of entry is in the intestinal tract. It exists in two forms,—the active and the inactive (cysts). The transfer is by cyst only, through carriers or active cases. The organisms are taken into the gastro-intestinal tract through contaminated food or water. The active amoeba are killed by the acid gastric contents, but the cysts pass through unharmed.

The incubation period is approximately from seven to ninety days. I have seen several patients whose diarrhea started exactly seven days after infected food had been eaten; several whose symptoms developed a month after infected food had been eaten; and one case in which the wife developed diarrhea in October, 1933, and the husband on March 15, 1934, both patients having been at the same source of infection at the same time. Undoubtedly, the husband was harboring the entamoeba all this time without symptoms. His first symptom appeared shortly after an attack of influenza. Thus, five months had elapsed from the time the contaminated food was ingested until the symptoms appeared.

Numerous classifications have been offered, but for the sake of simplicity I shall divide the cases into the dysenteric and the non-dysenteric types.

The symptoms of amoebiasis are not constant. Patients may harbor these organisms without presenting gastro-intestinal symptoms. Their only complaint may be loss of weight and a feeling of malaise. Stool tests will reveal the presence of amoeba. Other patients harboring the organisms will present definite dysenteric symptoms. In a great number of these cases the diarrhea is intermittent in character; in others the diarrhea is persistent over a period of weeks and sometimes months. In the acute, or dysenteric case, the symptoms are diarrhea, tenesmus, loss of weight, and loss of appetite; there may be a slight elevation in temperature. There may be from ten to forty stools a day, and usually no blood until secondary ulceration of the colonic mucosa has taken place. These symptoms may subside without specific treatment, only to recur at a later date. I feel that the following history illustrates this statement:

This patient stated that he had diarrhea which began six weeks previous to examination, and that he had had as many as eleven stools daily. The diarrhea lasted for ten days, and then from that time until two days previous to examination the patient had been comfortable, with the exception of not feeling "up to par". During the two days preceding the examination the stools had become loose and frequent. At the onset of his disease he had taken paregoric and bismuth. No stool tests had been made, although he had given a history that would lead one to suspect that he had an amoebiasis. This patient had definite amoebic ulceration of the rectum and sigmoid, and amoeba were found in the stool.

The variety of symptoms presented by the non-dysenteric type has led to erroneous diagnoses, followed by needless operations and the death of many patients. Undoubtedly we shall see a great number of patients with the non-dysenteric type of the disease whose symptoms may be loss of weight, fatigue, loss of appetite, and slight abdominal discomfort. Others may have acute abdominal pain, tenderness in the right iliac fossa, rigidity, slight elevation of temperature, or symptoms of acute appendicitis. Others may complain of vague abdominal discomfort, an unusual amount of gas, and epigastric fullness after meals. These patients should be thoroughly examined before operative procedure is instituted. The stool should be examined repeatedly for entamoeba histolytica.

The first site of colonization is in the caecum. From this point the infestation may spread lower in the colon as the amoeba are carried along by the colonic stream. The mucosa is penetrated where mechanical conditions are most favorable, that is, the flexures, the sigmoid, and the lower rectum. The appendix and the gall bladder often harbor the cysts and act as foci of infection.

Arnold divides the organism into the tissue-living amoeba and the lumen-living amoeba. The change from the lumen-living to the tissue-living amoeba may be brought about by altering the host in some manner, as, for example, by an infectious disease or some gastro-intestinal irritation during the hot weather. During the change from the lumen-living to the tissue-living amoeba, undoubtedly the amoeba burrow through the mucosa of the colon where mechanical and chemical changes take place with the resultant ulceration.

Read before the Fourth General Session, 88th Annual Meeting of the Ohio State Medical Association, held in Columbus, October 4-6, 1934.

The ulcers may be found in any part of the colon, and in severe cases the entire colon is involved. Amoebic ulcers are pathognomonic. The ulcers are round or oval, punched-out with definite undermining of the edges. They vary in size from two millimeters to two centimeters. The mucosa between the ulcers is normal. Secondary ulceration occurs and may make the proctoscopic picture confusing, but by careful study of the mucosa the slightly depressed, or the definitely punched-out ulcer with the undermined edges can be detected.

The entamoeba histolytica is a unicellular organism, and is to be differentiated from the entamoeba coli. Direct smears should be taken and placed in a small amount of normal saline, or, if the stools are examined directly, these stools should be warm and the examination made on a warm stage. The active entamoeba histolytica can be differentiated from the entamoeba coli by their size and motility. The entamoeba histolytica is larger with clear rapidly projecting pseudopodia. Red blood cells are found in the entamoeba histolytica and are never found in the entamoeba coli. By means of the iodine eosin stain one is able to differentiate between them. The cysts of the former are found to contain only four nuclei, whereas the entamoeba coli contains eight to twelve nuclei. A full discussion of these organisms may be found in any text-book on parasitology.

The diagnosis of amoebiasis is not difficult in most cases. After a general physical examination a thorough proctoscopic examination should be made. If there is active ulceration, a diagnosis of amoebiasis can be made from the ulcers. If there is any doubt, direct smears should be taken from these ulcers and examined on a warm stage. There has been much discussion among those not familiar with the picture as to the diagnostic value of these ulcers. Definite, rounded, punched-out ulcers do not resemble any other type of ulcer seen in the rectum and sigmoid.

A patient with any of the symptoms mentioned above should, of course, have a general physical examination. One of the most important procedures is the proctoscopic examination. A differential diagnosis should be made between amoebiasis, chronic ulcerative colitis and tuberculosis of the colon. Carcinoma of the colon should also be considered, since the symptoms of carcinoma are not constant and may appear not unlike the symptoms of any of the three diseases just mentioned.

Chronic ulcerative colitis is our most common colonic disease. Tuberculosis of the colon is much less common than we have been led to believe. The symptoms of these diseases are not unlike the symptoms of amoebiasis, except that the rectal bleeding is earlier in chronic ulcerative colitis. There is very little rectal bleeding in cases of tuberculosis of the colon, so that one is compelled to make a differential diagnosis. This diagnosis, in most cases, will depend on the proctoscopic examination. As has been stated, the amoebic ulcers are pathognomonic. The mucosa between the ulcers is normal. The rectal mucosa in chronic ulcerative colitis is involved in its entirety in a chronic inflammatory process. The mucosa bleeds easily when traumatized, may be granular, or may show minute ulcers. Rarely is there any normal mucosa found. The tuberculous ulcer varies in size, is irregular in outline, has a tendency to encircle the bowel, and has a dirty-white base. Tuberculous ulcers often become confluent, and there is marked undermining of the rectal mucosa. Direct smears often reveal tubercle bacilli. Carcinoma of the rectum and sigmoid reveals a definite mass which bleeds easily, is firm to the touch, and in these cases there is a sharp line of demarcation between the normal and pathologic tissues.

Roentgenologic studies of the colon are indicated after a proctoscopic examination has been made, and particularly if the proctoscopic examination is negative. Unfortunately, these patients usually have had a complete gastro-intestinal roentgenologic study before a proctoscopic examination is done. These studies are often misleading, in as much as they are often negative, especially in cases of amoebiasis. It is often difficult on viewing roentgenologic plates of the colon to make a differential diagnosis except in tumors of the colon. Of course, in cases of chronic ulcerative colitis, the sigmoid, descending colon, and oftentimes the entire colon, shows a lack of haustral markings or what has been spoken of as a "gas-pipe" bowl. It is much more difficult to make a differential diagnosis between amoebic dysentery and tuberculosis of the bowel, since the picture is somewhat similar in the two cases, especially if the ulceration is marked.

On numerous occasions, patients with the foregoing symptoms will present themselves. The proctoscopic examination will be negative and repeated stool tests will be negative for the entamoeba. Unless some definite finding is made to account for these symptoms, one is justified in using specific drugs as a therapeutic test.

Extra-intestinal amoebiasis, or a localization of amoeba outside the intestinal tract, presupposes a colonic lesion. The most common secondary focus is the amoebic abscess of the liver. These abscesses occur more commonly where there has been previous damage to the liver. Abscesses of the liver often develop with no history of bowel disturbance. Entamoeba histolytica have been reported to have been found in the brain, skin, spleen, and urinary bladder. All patients harboring the entamoba histolytica do not present pathological changes in the colon. I feel, however, that those who harbor these organisms and have had an acute dysentery at one time or another, have had definite ulceration. During

November and December, 1933, I examined eighteen patients having acute diarrhea; many of these patients were bed-ridden and had been for several weeks. In each case definite amoebic ulceration of the rectum and sigmoid was observed, and entamoeba histolytica were found in the stools.

The treatment of amoebiasis is of great importance because one is dealing with organisms that are resistant to drugs and with a disease that has a tendency to recur. The treatment should be supervised by someone thoroughly acquainted with this disease and should be carried on over a long period of time. Small doses of any one drug will not be sufficient to cure the patient. The patient should be kept under observation for at least two years, and during this time the stools should be examined frequently for amoeba and cysts.

There has been much discussion as to the efficacy of certain drugs, particularly emetine hydrochloride. Some men claim that this drug is too dangerous to use, while others feel that in the acute cases, and in amoebic abscess of the liver it is the drug of choice. I, personally, feel that emetine hydrochloride used cautiously is one of our best therapeutic agents. There is no doubt that it is a poisonous and depressant drug. During its administration the patient must be carefully observed for untoward reactions.

During the past few years I have carried out with success the following regime: The primary therapeutic course covers a period of four weeks. During the first week, the patient receives a daily intramuscular dose of emetine hydrochloride, 1 grain. The drug is stopped at the first sign of reaction. During the second week, carbarsone, 0.25 gm., is given three times a day. During the third week, ipecac, preferably alcresta tablets, in a dose of 40 to 60 grains, is given nightly in divided doses; and in the fourth week, vioform, 0.25 gm., is give twice daily. If the patient does not tolerate carbarsone by mouth, it can be given in the form of enemata. In many cases I have used kerosene enemata during the acute stages.

The symptoms usually subside after the second or third doses of emetine hydrochloride, but the treatment should be carried on as outlined. After a rest period of two weeks, the treatment should be repeated, and for a period of four months emetine hydrochloride, 1 grain, and a full course of carbarsone should be given one day each week. Severe cases should be hospitalized for at least two weeks.

SUMMARY AND CONCLUSIONS

Amoebic infection is not limited to tropical countries; it is greatly on the increase in the northern states. It must always be considered in any patient with intestinal upsets or other obscure conditions. The organisms are taken into the gastro-intestinal tract through contaminated food or water. The incubation period is approximately from seven to ninety days. There are two types of case: the dysenteric and the non-dysenteric type. The symptoms are not constant. The diagnosis is usually not difficult. A thorough proctoscopic examination should be carried out. Amoebic ulcers of the colonic mucosa are pathognomonic. The stools should be examined repeatedly for entameba histolytica. Direct smears should be made for the active and inactive forms. A differential diagnosis should be made between amoebiasis, chronic ulcerative colitis, and tuberculosis of the colon. Treatment should be supervised by someone thoroughly acquainted with this disease and should be carried out over a long period of time. The patient should be kept under observation for at least two years and during this time the stools should be examined frequently for amoeba and cysts.

1342 HANNA BLDG.

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— OSMJ —

Granted Ohio Licenses

The following physicians have been licensed by the State Medical Board through reciprocity to practice medicine and surgery in Ohio:

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THE SURGICAL TREATMENT OF TRACHEO-BRONCHIAL DIPHTHERIA

By J. D. FOUTS, M.D.,

DAYTON, OHIO

THE mortality in diphtheria before antitoxin was universally used was very high. Since that time, and in more recent years, the death rate has been reduced to a minimum, provided the disease involved the upper respiratory tract. In the cases of tracheo-bronchial diphtheria, the number of deaths is still exceedingly high. This presents a problem for serious consideration at the present time. In cases where treatment for toxemia, namely, antitoxin in proper dosage and other medical care has been skillfully administered, the mortality remains high in comparison with the other type. Is there more absorption due to anatomical relationship, consequently greater toxemia, or is it a result of toxemia plus slow or sudden asphyxiation?

Most of the fatal case records which I have studied, gave, as the cause of death, myocardial insufficiency, due to toxemia.

In studying approximately 250 case records at The Miami Valley Hospital, Dayton, Ohio, I found only one death in cases of upper respiratory diphtheria. This case developed an acute nephritis and died 10 days after admission. There were 27 deaths from the latter type. In approximately 50 per cent of these cases a post-mortem was done with similar findings in each case.

In this report I shall discuss no other treatment than the surgical, except to say all cases should have antitoxin and proper medical care. If possible they should be handled in a hospital. This is the ideal way. However, if not convenient or in an emergency, the case may be successfully handled in the home.

The problem which presents itself to the surgeon, is one of keeping the respiratory apparatus open with the least possible shock to the patient and trauma to the respiratory tract. This may be accomplished as follows:

1. By placing a tube into the larynx with the possibility of it being coughed out or becoming blocked by pseudomembrane and secretion.
2. By tracheotomy in which case the tube may likewise become blocked. The increased danger of mixed infection or pneumonia and an everlasting scar, which in a girl is not to be desired.
3. The direct method of examination and aspiration, if necessary removal of obstructive material by foreign body forceps.

The purpose of this paper is to present a report of my findings and conclusions in the examination and treatment of approximately 60 cases of acute infectious lower respiratory obstruction. Twenty-seven of these cases being diphtheria treated at The Miami Valley Hospital and verified by cultures, in which the direct method was used with two fatalities and 25 recoveries. In no case was an intubation or tracheotomy done.

Before using the direct method it was very difficult for me to decide whether to do an intubation, tracheotomy or to wait. This can be definitely decided by direct method.

ADVANTAGES IN DIAGNOSIS

The diagnosis of tracheo-bronchial diphtheria by direct method is about as certain as the laboratory, and certainly much quicker. It is impossible in almost all children under 10 years of age to make a satisfactory indirect examination before inserting the tube. An intubation or tracheotomy tube is inserted blindly because the patient shows signs of obstruction when the operator has no idea of the exact condition. This probably accounts for the almost universal belief that the obstruction is due to edema or pseudo-membrane. Edema was not present, or of little consequence, in any of these patients. Pseudo-membrane was most frequent, but the real obstructing agent was the muco-purulent secretion. Most of the obstruction was not in the larynx, but in the trachea and bronchi. There was little or no bleeding of consequence, as is the common belief. Occasionally the secretion aspirated was blood tinged. In some cases very little membrane was present and a great amount of secretion and vice versa. The tissues look reddened to some extent and slightly swollen but not edematous. In contrast to other forms of acute infection of the respiratory tract, especially streptococcus, the mucous membrane is fairly reddened, usually more swelling, secretion not so tenacious, less in quantity, aspirates much more readily and thoroughly. In most of these cases, patient is more toxic, pulse and temperature higher with dyspnea not in proportion to gravity of case.

A large majority of these cases are in a grave condition upon first observation. Most of them came from the middle and lower classes. They have either had no physician or a diagnosis has not been made until symptoms of dyspnea are present and many of them are emergencies, consequently they have had no antitoxin. The opinion prevalent that the membrane cannot be removed

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until 24 hours after antitoxin has been given, I found to be untrue. Practically all first aspirations have been done previous to the administration of antitoxin or within a few hours thereafter. The two fatalities occurred within 18 hours and the cultures showed mixed infection, both Klebs-Loeffler and streptococcus. I have discussed this method with a number of men who claimed the cases they saw were such desperate emergencies that nothing but intubation or tracheotomy could be considered. To this I must take exception because of the fact that with reasonable training and experience the patient can be given an adequate amount of breathing space more quickly than by intubation or tracheotomy. Many of these cases were of that type and in some it was necessary to insert a bronchoscope and use artificial respiration and oxygen. This is about as desperate a situation as one can expect to confront and hope to prevent a fatality. Stridor in all of these cases is relieved. Breathing is not normal of course and may be somewhat noisy, but the patient is comparatively comfortable and usually obtains several hours of much needed rest.

The armamentarium used consisted of a # 6, # 12 and # 16 Jackson laryngeal speculum and grasping forceps; a suction bottle attached to a Sorensen suction apparatus, with the tip about ¼ inch in diameter and long enough to reach the bifurcation of trachea; a small aspirating tube to aspirate the bronchi. The patient was placed in the Boyce position with the head supported by an assistant as in bronchoscopic examination. A bronchoscope should not be passed except in an emergency on account of the size and more liability to trauma. The number of aspirations varied from two to nine, and the time between aspirations varied from four to 24 hours. One case aspirated nine times recovered. This one had not been diagnosed and no antitoxin was given, because the first culture was negative. There was however, typical diphtheritic membrane in the fauces. The average number of aspirations was approximately, four, total number approximately 90. No case was done as an emergency after first aspiration. In practically every case, signs of obstructive breathing occurred for several hours, becoming more marked, and aspiration was done before alarming symptoms developed. The age limit varied from one to 43 years. Only one case was past 15 years of age. In this case, age 43, obstructive agent was pseudomembrane which acted as a valve in larynx and was removed on two occasions by laryngeal forceps. The laboratory report, as related previously on the two cases that died was a mixed infection, Klebs-Loeffler and streptococcus. Both cases were emergencies when admitted. Aspiration was necessary about every four hours. There was no evidence of stridor at the time or for several hours before death which occurred very suddenly before the nurse was able to summon an interne. These seemed to be toxic deaths.

COMPLICATIONS

All cases that recovered had no permanent complication. Voices were normal. One case developed a marked emphysema, extending down over the chest and up into the scalp. This disappeared in several days with no serious result.

DANGERS IN ASPIRATIONS

There is probably less danger in this method than any other, provided a differentiation is made between air hunger in extreme toxemia and obstructed breathing. I should not feel negligent, if I should have a fatality at the time of aspiration, provided I found marked obstruction of the respiratory apparatus. If the patient will not stand the small amount of shock in aspiration, that same heart would not last long under the strain of obstructed breathing. In the 25 cases treated by watchful waiting, intubation or tracheotomy and usually both, there was one recovery and the culture was negative for Klebs-Loeffler, 24 out of 25 died, three of which were mine. My death rate was 100 per cent. A great many of these were posted with findings similar in nearly all cases.

PATHOLOGICAL DIAGNOSIS

Diphtheritic laryngitis and tracheitis. Terminal right sided cardiac dilitation. Cloudy swelling of all organs. Status lymphaticus. Terminal bronchial pneumonia. These in general were the autopsy findings. It is not my intention to criticize the pathologist as he can only report his findings. This pathologist is one of experience and for whom I have a profound respect. However, I am wondering whether or not, if it were possible to examine all these organs during the acute or subacute stages of this condition, the findings might not be similar; leaving the chief cause of death due to asphyxiation.

CONCLUSION

Where symptoms of obstructed breathing are present, the direct laryngoscope supplemented by bacteriological examination affords the most accurate method of diagnosis.

Inspection of the larynx will indicate whether or not surgical intervention is necessary and also indicate the best method of relieving the respiratory distress.

Few cases of tracheo-bronchial diphtheria require operation, if aspiration is judiciously employed.

Direct laryngoscopy permits of the introduction of an intubation tube by visual guidance, thus diminishing the risk of trauma associated with the indirect method.

As yet a satisfactory statistical evidence is lacking. One only requires to witness the dramatic

relief following suction in certain cases of severe tracheo-bronchial diphtheria to form the opinion that this method of treatment is sane and worthy of serious consideration.

DISCUSSION

EDWARD W. HARRIS, M.D., Columbus: I am in hearty accord with Dr. Fouts' ideas on this subject. We have been employing this method of treatment here in Columbus for the past seven years. However, we have not had the opportunity of seeing as many cases as Dr. Fouts. For some reason or other, there seems to be more diphtheria in the Dayton area than in Columbus. I do not suppose more than ten cases of laryngeal and tracheo-bronchial diphtheria have come under our care in this period.

There is another point to be mentioned; namely, that occasionally a child, sent into the hospital with a diagnosis of croup, upon laryngoscopic examination will be found to have a foreign body, such as a safety pin or egg shell causing laryngeal edema. Blind or indirect intubation in a case of this kind might only cause an unnecessary death by further traumatization of the already injured tissue.

I am very glad Dr. Fouts has brought this matter to our attention and believe it will be almost universally employed as more and more men hear about it.

EDW. KING, M.D., Cincinnati: To those of us who have seen and treated stricture of the larynx in children, the methods presented by Dr. Fouts for prevention of this distressing complication of diphtheria are most welcome. I know of no condition that is more difficult to handle. The ingenuity and patience of the surgeon is severely taxed. Dr. Fouts is to be congratulated on the results he has obtained and commended for the labor and vigilance which these cases require. Many hospitals are unable to follow out this procedure because skilled operators are not available day and night.

How much better it is to take a look at the larynx and trachea before blindly pushing in an intubation tube. There is no doubt that the membrane alone produces enough obstruction to warrant the use of measures for relieving the obstruction and it is certainly more feasible to remove this membrane than to insert a tube which may merely dislodge it downward into the trachea. No matter what experience the operator has enjoyed, the tube itself may produce ulceration and the stricture will result.

The examination and suction are simple procedures in the hands of an expert. The results of this method of handling speak for themselves as exemplified by the statistics quoted by Dr. Fouts and those quoted by Bailey in the August, 1934, number of the *Archives of Otolaryngology*.

Laryngeal diphtheria requires hospitalization. If the emergency arises in the home, it is safer to do a tracheotomy rather than to resort to intubation, unless the patient can be transferred at once to a hospital where someone trained to intubate is constantly in attendance. It is important to remember that a tracheotomy should not be put off too long for fear of disastrous consequences. If intubation fails, a tracheotomy certainly is indicated. The emergency tracheotomy is dangerous and should be avoided. If the air passages are obstructed so that an emergency exists, the bronchoscope or the laryngeal tube should be inserted while the tracheotomy is under way.

THE PROBLEM OF PROLONGED DISABILITIES

By C. D. SELBY, M.D.,

TOLEDO, OHIO

THIS discussion concerns injuries of industrial origin only, which will be implied throughout.

Disability may be defined as the period of unemployment following an accident. It is determined primarily by the severity of the injury and structures involved, conditions over which a physician has no control. He accepts an injury as he finds it. His responsibility begins after it has occurred. Even so, poor results and delayed recovery are reflections against his skill. It is therefore important that our profession study carefully the problem of prolonged disability.

It is well that it be clearly understood what prolonged disability is. When a physician assumes the care of an injury, he offers an estimate of the time required for its repair and gives an opinion as to the probable condition on recovery. He may permit himself some latitude, but both the patient and his employer accept the estimate literally, and if the recovery overruns the estimate, regardless of cause, it becomes a case of prolonged disability.

A few embarrassing explanations and a doctor tends to become overly conservative in his prognoses. This is also bad in that the patient is thereby encouraged to further disability. It is unwise to be too frank with patients for this reason. On the other hand kindly professional reticence is good therapy. It is wise to be frank with some responsible, sensible member of the family and the employer.

Every injury has what may be regarded as its normal disability. Extensions should call for study, in order that causes be removed. They may be divided into four classes; those which are purely professional or medical; those which rest in the patient and are not medical, those under

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the control of the employer, and those which result from the principle of acceleration.

THE MEDICAL PROBLEMS OF PROLONGED DISABILITY

The diagnosis of injuries is the most difficult in the whole field of medicine. Injuries are individualistic. Precedents are of little value. Patients are in pain, worried, maybe excited, if not unconscious. Friends are excited, inquisitive, and frequently critical. The doctor must work under pressure. His first effort is to relieve urgent symptoms and assure life if possible. After this a deliberate study should be made, from the standpoints of the region and structures involved, the nature and direction of the violence, the instrument of injury, and pre-existing diseases that might influence recovery. A prognosis should not be offered till this is done.

There are three sources of error. A single injury may be underestimated. Secondary injuries may not be found. Complications may not be anticipated.

THE DIAGNOSIS OF SINGLE INJURIES

If it be a laceration or an incised wound the chances of error are not great because the injured structures are or can be made visible. The pathology is all objective. In a contusion or any injury without a break in the skin, we are blinded to the underlying pathology. But we do have the point of impact. With that in mind supplemented by a knowledge of the nature and direction of the force, we can visualize the structure that might be involved, subsequently confirming by such tests as may be appropriate to ascertain injury of nerve, artery, muscle, tendon, bone or ligament.

Many of us think of fractures in injuries of this type, get an *X*-ray and if the report is negative, assume that there is only a contusion. If we but consider the force applied, and realize that it was sufficient to suggest a fracture, we will know there could have been soft part damage of a degree to warrant further study. This is especially important in injuries of the forearm. Doubtless all of us have seen permanent impairments of hands and fingers follow oversights in this region. When we have a fracture, we think of damage to the bone and rate the injury in accordance with what the *X*-ray shows. The fracture may be perfectly reduced, the outlook may be favorable from an osteological point of view; yet there can be for example severance of the musculo-spiral nerve, or other equally important structures. Fracture of the skull may or may not be serious depending upon the intracranial pathology.

In a paper of this nature it is not possible to name the injuries that can happen and the special hazards to recovery that are peculiar to each, so I want to leave this thought as an admonition applicable to all; that every structure and organ in an injured area should be assumed to be damaged until by appropriate test it is proved to be intact.

DIAGNOSIS OF MULTIPLE INJURIES

Failure to find secondary injuries is a frequent cause of prolonged disability. All cases of multiple injuries have those which are obvious and more or less urgent. They command attention at the expense of the less obvious and urgent, and the latter are missed. Under no circumstances should it be assumed that there are no other injuries if the history suggests a multiplicity of lesions. Many times the patient says he has no other injuries, but his statement is not dependable. He may be in such pain that he does not know.

Falls, as an illustration, are notorious in this respect. We will assume a case: A man has fallen. He has a wound on his head, a fracture of a femur. He is unconscious, in shock. He is treated for shock. The wound is dressed and the leg is splinted, both temporarily. The patient recovers from shock and later becomes conscious, the cerebral crisis is over—no fracture of the skull. The fractured femur is reduced and held in fixation. The scalp wound is sutured. The patient remains in bed until the fracture is solid, no other complaint. When he starts to walk, he speaks of a painful back. An *X*-ray shows a compression fracture of the third dorsal vertebra. The patient goes back to bed and into plaster. The estimate of disability increases from a possible six months to a year or more. The doctor is embarrassed, the employer shocked and the patient discouraged. Worse than that, he may be a permanent total disability.

It is the unusual of men who surmount obstacles of this kind. Most of them are content to exist on the fruits of disability. It is therefore essential that the whole record be written as early after an accident as possible, in order that all parties can adjust themselves to the probable outcome.

UNANTICIPATED COMPLICATIONS

Complications always increase disabilities. The most frequent of course is infection. Experience has taught us when to expect this, and we have learned to adjust our prognoses to that possibility. Preventive treatment has assisted in avoiding anticipated infection. So infection is not an important source of prolonged disability, in the sense the term is used in this paper. The important disabling complications are those which arise out of pre-existing diseases, such as diabetes, syphilis, tuberculosis, focal infection and arthritis. It is not necessary to emphasize the importance of determining the presence of these, as all have had experience with them, but the

possibility of pre-existing diseases should always be in mind, and no patient should be deemed free until proved so by adequate examination.

Complications of this kind always introduce puzzling questions. Does the pre-existing disease prolong recovery of the injury, or does the injury accelerate the disease. Of course the result is always the same, compensation over a long period of disability. I am personally of the opinion that the responsibility in cases of this nature should be more equitably divided between employer and employee.

We have then three sources of prolonged disability, which originate in omissions of diagnosis and are therefore purely medical; undervaluation of single injuries, ignorance of obscure secondary injuries, and failure to recognize the presence of diseases capable of affecting the injury or being affected by it.

THE PATIENT HIMSELF

There are many honorable, loyal, diligent capable men in industry, fortunately in sufficient numbers to have elevated our American industrial class to its present world-recognized high level. There are a few of the opposite type who take advantage of the opportunity of an injury to prolong disability for the modicum of compensation they may derive from it. I suppose we are all experienced with cases of this character, and it may be perfectly useless to discuss them. However, to ignore them does not solve the problem. Discussion may. They may be divided into six classes: (1) the timid fellow, (2) the heavily insured man, (3) the man over fifty, (4) the lazy fellow, (5) the litigious, and (6) the man for whom there is no work.

The timid man:—He has our sympathy and he can be helped. He is the one who wants to go back to work but is afraid of a setback. He needs encouragement and perhaps a temporary change of job. It is unwise to put such a man back in a job where he feels he is crowded. I remember one who had the tendons cut on the back of his hand. They were successfully sutured and healed, but with some temporary stiffness of the fingers. He needed to use the hand. The right kind of work was his best treatment. But he was timid, said he would exercise the hand at home, a kind of treatment that never succeeds, and did not in this case. He was finally persuaded to go to work, and was put on his regular job in a team of four paid by the piece. His team was slowed, and while they were tolerant, the fact that he was cutting down their earnings was too much for him. He quit, and there was nothing to do but put him back on compensation, which bid to run indefinitely and to end with possibly a permanent impairment. The superintendent, claim man, doctor and patient were called together and talked the problem over. The man went back to a job he could do, requiring the use of the hand, and he was paid full wages. Function was restored, confidence maintained and loyalty preserved.

A word about wages to these temporarily crippled employees who are persuaded to take up so-called light work, usually a kind of work that pays less than their average earnings. They should not be penalized by a lower wage, because of conditions which to them are without personal fault. On the contrary, their usual wage, always more than compensation, is an inducement that makes a temporarily inferior job more desirable than the leisure of compensated disability. This is worth while because the leisure of compensated disability is like a habit-forming drug, and this type of employee is the kind that develops such habits. He lacks that strength of character, the driving power, that enables him to force his way through obstacles. These timid men must be induced to work as soon as possible, under intelligent supervision.

The Over-Insured Man:—This is often the story. A negro came in one afternoon with a strain of the back, but without obvious injuries. He was reassured and went home with the appearance of gratitude. He improved for a while and was thought about able to go back to work. Then he came in with a recurrence, which he explained by saying he had tried to lift a bucket of coal. The treatment was started again, and he improved again. In fact he got so well he was effervescing with health and humor. He showed how high he could kick, was going to work soon. A couple of days later he came in with a second recurrence, could hardly move. He had tried a little exercise to get ready for work, had lifted another bucket of coal. For several months this man went through these cycles. Apparently a frank sincere odd fellow and religious, he was never doubted, but one day I happened to see him walking spritely near his home. The same afternoon came a hurry-up call to visit him. We couldn't go. A half hour later he appeared at the office, in bad condition. During all this time, he had not offered any insurance papers. He was getting state compensation and no more. But suspicion was aroused and he was asked about insurance. He had two policies with a neat weekly income from each, and another physician had been filling out the papers.

A well-insured disability is always to be regarded with skepticism, particularly if the symptoms are subjective. In a large percentage of these cases so long as compensation continues, they will not work. The obvious remedy is to stop compensation, but the difficulty is to pick out the meritorious. The physician, and I believe the employer too, would rather give all the benefit of doubt than to work a hardship on one honest

man, with the result that many petty grafters get by.

Man Over Fifty:—I am often asked to do reconstructive surgery or undertake physio-therapeutic treatments on men over fifty who have impairments, and have always tried to help them. It gradually dawned on me that this class did not respond satisfactorily, though the physical results were good. The group was analyzed and regretfully it was learned that many would rather have handicaps with compensation, than cures with the necessity of working. They doubtless believe they have done their share and are content to retire on compensation as a pension. These men are to be recognized by the absence of complaints. They are not critical, as many others of the chiseler class are. Certainly there are some exceptions and they should be given the benefit of reconstructive treatment. They will show good intentions by trying to work despite handicaps. And when they do I no longer hesitate to help them. But they must show good intentions first.

The Lazy Man:—He is usually affable, good natured, and treats you with much respect. You feel flattered with the fine impression you are making. While he improves from day to day, never criticizes and is always grateful, he never quite reaches the time when he feels able to work. He leaves you after each visit with the impression that he is just about well and will probably be fit to work the next time you see him. He is clever. He accumulates quite a disability before you suspect his true nature, and when you do he is not hard to handle. He is purely a bluff and capitulates gracefully when called. The important man in this classification is the one who has had a serious accident and capitalizes on the sympathy that all naturally have for one who has been badly injured. The stage is all set for him to become a big-time grafter. There are a wide variety of lazy men who try in one way or another to extend their disabilities. It is not necessary to give each the dignity of special mention. Sooner or later they divulge themselves and must be treated accordingly.

The Litigious:—I suppose there is justification for recourse to law, but experience leads me to the conclusion that most of those who find it necessary are either looking for something in the way of what they regard as easy money, or attempting to cover up personal faults or weakness, or they are motivated by resentment.

I have always had the feeling that those who try to get something for little or nothing pay the most dearly in the long run. That old law of compensation still holds good. But the temptation is so great that a large class succumb. There is something fascinating about easy money. It is not my desire to moralize, but I do think that the trend of modern sociology and government is such as to foster rather than to retard this tendency. Unemployment insurance and sickness insurance are theoretically beautiful, but in my judgment are fraught with great menace to the stability of our people and a greatly added burden to industry.

Unemployment:—This last thought was a digression but it leads to a consideration of the workman who has been injured and whose employer in the meantime has had to close his shop indefinitely. It is difficult to say in these cases where compensation should stop. With no job in sight the workman cannot be expected to help, and in many instances the compensation becomes plain unemployment insurance. There is only one solution, and that is for the doctor to pronounce the patient recovered when he is. It isn't so easy for a physician to say a man is well. That may be his opinion, and he does not hesitate to express it. But the employee says, "No, I'm not well, I still have pain. I can't work." And four or five months later the compensation board gives him the benefit of the doubt.

The trouble is, our modern system of compensation has given the injured man who wants to practice deception an opportunity to do so, and he has cultivated a consummate skill. Is it any wonder that then unemployment comes to us, disability periods are prolonged and compensation boards are overwhelmed with applications for re-establishment of old claims? I do not want to give the impression that I look upon all injured workmen as grafters, and compensation for injuries as an evil; not that, but I do believe there should be no further extension of compensation until society is able to regulate it better, or shall I say is better able to appreciate it.

THE EMPLOYER

Placement of handicapped employees:—The employer is sometimes at fault, in that he does not encourage injured men to stay at work or to come back early when disabled. Here is what often happens. A man gets a minor injury, which interferes with his usual work. There are many other kinds of work he can do, but no vacancies. It is a question in the employer's mind, whether it is better to make an opening for this man or let him go on compensation. If the employer considers only the immediate operating cost, he probably lets the man go on compensation. But *is* it cheaper, in the long run, to pay these losses in compensation or in operating costs; I will leave that with you as a rhetorical question. However, it should be remembered that compensation is a total loss, while temporary changes in employment are not. Furthermore, where a man is doing temporary work, or the so-called light

work, he is actually working. When he is on compensation he is loafing.

THE PRINCIPLE OF ACCELERATION

A corollary of this tendency toward over-compensation is the creation of derelicts, men who want to work but are kept idle because of the compensation hazard. I refer to the physically handicapped who cannot pass an examination for work. Theoretically the examination is to determine what kind of a job a man can do, but frequently it serves to keep the physically handicapped off the payroll.

Let us take tuberculosis for example. There are many kinds of work a tubercular can do, with benefit to his health, and tuberculosis is not on the specified list for which industry is responsible. It would seem perfectly safe to employ workmen with tuberculosis in certain stages, under recommendation of the doctor, and the employer could feel he is doing a fine thing. Here is the deterrent. If an accident happens to accelerate the tuberculosis, the employer pays for it. This is not pure supposition. A man with controllable tuberculosis of the lung is walking across the plant yard. He stumbles. The effort starts a pulmonary hemorrhage, and the lesions are accelerated. He goes to a sanitarium and is off six months. Just tuberculosis? Yes, but it began with an accident.

There is the same possibility in heart disease. If a man dies of this while at work, and it can be proved that he was doing something a little out of the ordinary at the time, which required perhaps a bit more exertion than usual, there is a death claim. When compensation acts first became effective it was difficult to get a hernia recognized. There had to be external signs of injury. The hernia with external violence is rare, so few were recognized. Now, if the admission examination shows no hernia and one appears later, it is an ingenuous man who cannot get compensation. Or if a hernia be found in the preliminary examination and some slight accident aggravates it, or seems to, it becomes a compensable condition. In this manner, through the principle of acceleration, industry is constantly accumulating additional responsibility for conditions over which it has little or no control. A diabetic employee crushes a toe. It becomes gangrenous. The leg has to be amputated. The man may even die. What is the compensation for a crushed toe in comparison with that of amputation or death? I cannot see why industry should be held for acceleration of a pre-existing condition. Let me put it this way, if industry is held to the principle of acceleration, the inevitable result will be a gradually enlarging group of unemployable derelicts. This, I am convinced, is a most unfortunate evolution of the theory of compensation, because it not only drives the crippled and the diseased from gainful occupation, but it also alienates a powerful ally of preventive and curative medicine.

Antituberculosis workers know this. They have come to depend more and more upon industry for help in the prevention and cure of tuberculosis Industry is a splendid point from which to attack this problem, because of its organization, medical service, etc., and it should be encouraged to accept further responsibilities of this and similar nature rather than penalized for doing so. Unhampered and voluntarily, I am satisfied industry would go far in this direction, but before it can be expected to do so, it must have assurance of a definite limit to which compensation can be extended and protection against the effects of the principle of acceleration.

CONCLUSION

The causes of prolonged disability are failures in diagnosis and the consequent inaccurate estimation of disability, voluntary prolongation by the patient and inability of the employer to provide work for partly recovered and crippled employees. The principle of acceleration tends to aggravate the problem, by confusing the physician, encouraging the employee to disability and disturbing the employer's economic peace of mind. It should be more accurately defined.

316 MICHIGAN STREET.

—OSMJ—

Surgical Meeting in Cleveland

The Sectional meeting of the American College of Surgeons, which will be held in Cleveland, April 4 and 5, with headquarters at the Hotel Statler, is in charge of an executive committee consisting of Dr. Wm. E. Lower, chairman, Dr. John Dickenson, secretary and treasurer; and Drs. M. E. Blahd, C. A. Bowers, R. S. Dinsmore, H. L. Frost, C. H. Lenhart, G. P. O'Malley, H. L. Sanford and Wm. B. Chamberlain. Chairmen of the sub-committees are as follows: Registration and Information, Dr. Dinsmore; Program, Dr. Bowers; Clinics, Dr. Lenhart; Community Health Meeting, Dr. Sanford; Publicity, Dr. O'Malley; Speaking Engagements, Dr. Blahd, and Finance and Auditing, Dr. Frost.

The two-day meeting will consist of morning clinics in several hospitals, and the afternoons and evenings are to be devoted to round-table conferences and lectures. On Friday evening, April 5, a public health meeting will be held in Music Hall of the Public Auditorium, when several outstanding speakers will be heard. Fellows are expected from the following states: Michigan, Indiana, Ohio, Pennsylvania, New York, and from the Province of Ontario, Canada.

WOMEN'S CONTRIBUTION TO THE REDUCTION OF MATERNAL MORTALITY

By MABEL E. GARDNER, M.D.,

Cincinnati, Ohio

A NEED

THE bugaboo of our so-called "Shocking maternal death rate" continues to stalk the profession and haunt the intelligent woman who contemplates maternity.

The fact is that in spite of much talk about the matter, and investigations of the causes the rate still stands, at its original figures, six out of every thousand. The question of whether it is higher or lower than that of other countries is beside the point. The fact that it is higher than it should be, that valuable lives are being lost, lives that could be spared if proper care were exercised, is the issue before us.

We have on the one hand a body of physicians, trained to skillful service in these cases. We have on the other a vast and even in spite of depression and birth control, a practically undiminished number of women needing this skilled service. What is the chasm that separates the needy from the rescuer? What is the bridge that is necessary to bring them together? The chasm is ignorance. The bridge is the education of the women themselves.

Time was when a woman was a degraded creature, when bearing a child was a polluting procedure, when for a physician to attend a case of childbirth was to lose cast with his confreres. This state of affairs has passed away. Then for a time it was good form for the husband to appear at the physician's office and say, "My wife is going to have a baby next week. I will need your services," and the doctor peering over his glasses would say, "Uh,-uh, well, when the pains are three minutes apart, send for me."

It takes education to eradicate this custom, education of the doctor, the husband and the woman, and the greatest of these is the woman.

THE CHANGE OF STATUS OF WOMEN

We have now a new order of things. Woman is no longer a chattel, owned to bear sons to send to war, the loss of whom is a small matter and easily replaceable if lost. She is now a citizen in her own right. She now claims respect and scientific care in her illnesses.

She has moreover entered into life and activities of the nation till we feel on every hand the force of her influence. She has organized and maintains a giant educational structure, the woman's club which enrolls in its membership all clases of women, except the very poor and ignorant, and to these it extends an educating protectorate by way of parent teacher's, mother's clubs and home economic classes which are a part of the woman's club movement. This Federation claims a membership of approximately six hundred thousand women. Every manufacturer and politician who has a new cause to promote from the newly patented safety pin to the latest social enterprise to be lobbied through Congress recognizes the power of its influence and seeks to further his ends by attempting to get a hearing before it.

Here then, is the bridge which medical science should use to bring about the result it desires, namely, the reduction of the death rate of the class from which that organization recruited.

WHAT MUST BE PRESENTED

If we are to successfully educate women to their own needs we should have well in mind the data which must be presented. For be assured no slip-shod methods will be effective. These are busy people, trained to think constructively, alert and well informed and quite able to detect indifferent and inferior presentations. Their programs are already crowded with matters of vital import and luke warm or poorly prepared speakers will not be received. However, this subject of maternal care can be made to live and glow. The growth of the embryo, the anatomical changes of the maternal organism, the psychic and emotional responses evoked by pregnancy form a fascinating setting for the fact one wishes to drive home, that pathological changes may occur, the knowledge of which can only be detected by skillful physicians at frequent examinations throughout the time of pregnancy.

The sympathetic interest in the early development of the foetus is the surest preventive against the induction of abortions, which practice raises our death rate 25 to 35 per cent and accounts for a large part of our preventable septicemia. Since our laws against the professional abortionist are so inadequate our only hope of curtailing his nefarious practice lies in educating away his clientele.

Our hope of reduction of death from hemorrhage lies in educating women to the need of diagnosis of the position of the child, the proportion of the child to the pelvis, to the taking of blood tests for the determination of calcium, anaemia, and syphilis and to other physical examinations that shall reveal organic lesions such

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as damaged heart, kidneys, or the presence of chronic infections such as tuberculosis and others.

WHAT HAS BEEN DONE

An outstanding example of maternal health education of this nature was the booth of the Medical, Dental and Allied Science Women at the Century of Progress. A dignified, accurate and attractive lecture was presented on this subject every day for the duration of the fair. Thousands of women, as well as children and men received knowledge of the proper care of pregnancy that will no doubt, influence our death rate in the next few years.

Mention should be made of the campaign in Cincinnati, by which contact is made with the women's clubs and speakers provided from the Medical Woman's Club to give authoritative information on this subject.

The State Medical Society of Illinois last year had a "Woman's Day" presented by the medical women, at which examples were given of talks to be presented to lay women's groups, and these talks were freely criticized by those present until they were made scientifically correct and attractive and later were printed for use in health campaigns in the Federated Clubs.

THE REACTION

The surprising thing about this type of education is the reaction. The profesion has talked for several years to the physicians about the necessity of pre-natal care. The average physician has in the back of his mind the knowledge of the possible care he might render. He often fails to exercise his best efforts, however, due to diffidence or native,—what shall we say—inertia?

If, however, women are well aware of the necessity of pre-natal care and also informed as to what constitutes adequate supervision they will sweep aside pseudomodesty and diffidence, and rally the physician's luke warm efforts and secure for themselves the examinations and attention which are necessary to assure a safe journey to the land of motherhood.

The physician who does not know will be driven to learn, the one who knows but is dilatory, will be spurred to apply his knowledge. When a woman realizes that it is not enough to merely send a bottle of urine to the physician every month, but that blood pressure and weight determination, heart and other physical examinations are indicated also at regular intervals she will secure it for herself.

THE PRESENT NECESSITY

Therefore, in view of the prevailing tendency to inertia, and in line with the movement already inaugurated in other places to secure more universal education of women to the need of prenatal care and knowledge of what constitutes adequate supervision, it would seem a logical thing for this Ohio section of the Medical Society to appoint a committee of medical women who should contact the women's clubs of this state in order to secure places on their programs to educate women in pre-natal care. They should also organize a corps of speakers who shall be trained to give attractive and scientific presentations of this subject.

By so doing I believe we shall have set ourselves on the way to make a more pronounced reduction of the useless loss of life from child-birth which we so much deplore.

KEMPER LANE APARTMENTS.

DISCUSSION

HELENA T. RATTERMAN, M.D., Cincinnati: Dr. Gardner in her well prepared paper has given us much to think about and what she has said is a challenge for us to bestir ourselves. She is perfectly right in stating that it is all important to make a carefully prepared presentation of the subject of maternal care when we have the opportunity to do so.

In the main the general attitude of mind toward childbirth is a careless one. Much is left to chance and too often the wide margin of safety is demonstrated. Our thinking needs overhauling. Childbirth is still a by-product of housekeeping. Unless there is an abnormality of grave portent the routine performance of the usual home and family duties is expected of the pregnant woman. Think how exaggerated is the training and care of the football athlete for months leading up to some important game. And yet how unimportant a performance is the participation in a football game as compared with the successful bringing forth of the latest model of homo sapiens.

The wealthiest and the poorest have the aid of the most careful supervision. They are informed as a rule. Prenatal clinics are now generally established. Even so it is not always possible for those who attend these clinics to cooperate fully. But in so far as they can, these women have learned what is good practice and supervision and get it for themselves.

However the classes in the lower and moderate and even the comfortably well to do economic levels are not informed and here much might be done by focusing thought on maternal care and thus establish a new attitude of mind toward this service. We must sell them the idea of prenatal care. We must revise their thinking so that the increased budgeting becomes a matter of course and prenatal care the accepted thing which no self respecting family would think of doing without.

The need must be made as apparent as junior's need for new shoes. Thus the pride and self respect of each family unit will rally to the cause and mother herself will realize her own obligation to provide herself with every aid to best accomplish the task in hand. The replacement factor in life will always play an important part. It should be possible of accomplishment without disaster except in the very abnormal and in that small percentage of cases our deviation from perfection in any endeavor.

We have too many one child marriages and perhaps we have too many homes where additions appear almost yearly. Two to four children in each family would mean an average of three pregnancies for each mother. If we look upon

this production average as requiring three years concentration on it out of a possible forty or more active years it is not a great toll. It need not interfere seriously with any organized life business or interest or with the social or civic activities of the individual.

This housing and caring for the little guest within the body of the mother is a dignified job and worthy of careful thought. Good form requires a home in order when entertaining a guest. Just how well the body structure of the mother is fortified is shown by the frequent devastating effect of the added burden of a pregnancy.

We are more and more accepting the gospel of keeping fit. The old idea of one pregnancy justifying a life invalidism or one operation furnishing an alibi for all the remaining years of life is exploded.

Therefore let us adopt Dr. Gardner's recommendations and make this attempt to raise the status of childbearing and thus lower the mortality rate. As she puts it, whether our maternal death rate is higher or lower than that of other countries is beside the point. The fact remains that it is higher than it should be.

G. WAYNE BREHM, M.D., Columbus: I have attended these meetings for the past twenty years, and have heard many such excellent papers as Dr. Gardner's and Dr. Brand's relative to better obstetrics and lower fetal death rates, but to my knowledge not a thing, except the reading of papers, has been done by this section. Those physicians who give proper ante partum, partum, and post partum care are the ones attending our meeting today, while those that do not give such care do not attend.

We berate State Medicine, critize all the cults, and all the social organizations for their interest and work toward better obstetrics, yet we do practically nothing ourselves. Dr. Gardner says the women's clubs of America have taken up our problem and are demanding adequate attention and care. It seems to me quite a patriotic challenge to this section that the women's organizations should be compelled to do the task we have neglected.

Is it not time this section did something to contact those of our profession that need instruction or advice regarding the proper care of obstetrical patients before we find ourselves in the next five or ten years a branch of the women's clubs of America?

SOME UNUSUAL COMPLICATIONS IN MALARIAL THERAPY

By LOUIS J. KARNOSH, M.D., and GUY H. WILLIAMS, JR., M.D.,

CLEVELAND, OHIO

THE literature on malarial therapy and its complications is extensive. The effects of hyperthermia in general has become a subject of great interest because of its therapeutic application not only to paresis but to arthritis, to neurovascular disorders and to various acute focal diseases of the central nervous system. Its dangers and limitations have been pointed out in recent years, particularly by a group of investigators at the Albany Medical School,[1] who noted the outstanding morphological changes such as peripheral hyperemia, cloudy swelling, dehydration, glycogen depletion and focal hemorrhages in the gastro-intestinal tract. These studies did not, however, elaborate upon the specific nature of some of these lesions and it remained for other researches such as those of Bruetsch[2] to look into the peculiar cellular reactions induced by the malarial parasite, thereby adding to the further understanding of these complications. These unusual manifestations are not without interest to the neuro-psychiatrist and will be briefly presented.

On the clinical side a survey was made of 580 cases of general paresis who were subjected to the paroxysms of tertian malaria. Prime evidences of serious complications and harbingers of disaster were found to be these clinical signs: 1) a paroxysm with a temperature of 41° C. or over; 2) a low chill temperature accompanying an unusually high pulse and respiratory rate;

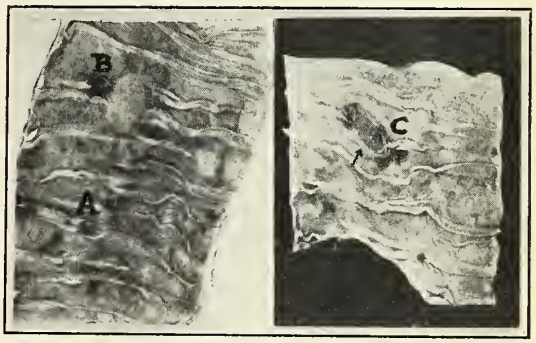


Figure I. The gross appearance of the intestinal lesions found in malaria. About A are seen the ecchymotic patches; at B may be seen a bleb-like hematoma; at C is a deep ulcer, with little induration at the border which is discolored by hemorrhage.

3) a fever which remained for over eight hours after a normal chill peak; 4) a blood pressure under a systolic of 100 and a diastolic of 60 mm.; 5) a blood urea of over 60 mgms. and 7) cyanosis of any degree.

Delirium, confusion and excitement during the height of the fever occurred in over 75 per cent of the cases and these cannot in themselves be regarded as having significance. The same can be said of herpes of the lips and face. Physical

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Figure II. High power section through the base of a malarial ulcer showing the occlusion of small vessels with many endothelial cells which are stimulated to phagocytic activity by the presence of the malarial organism. The lesion appears strikingly similar to that found in intestinal ulceration associated with necrotizing arterial disease of he kidney.

habitus offered no reliable index as to resistance, robust individuals developing serious collapse just as often as the small, wiry, asthenic patient. Roentgenologic diagnosis of dilatation of the aortic arch, unless it was associated with pronounced clinical symptoms, did not contribute to a greater number of fatalities than did a negative finding in this respect.

Fatalities from all causes in this group amounted to 74, or 12.7 per cent. Of bronchopneumonia which was found in 35 per cent of these little need be said. The very unsatisfactory diagnosis of circulatory failure in 32 cases could not be clarified because no post-mortem examination was allowed.

In five patients the treatment was suddenly terminated because of the appearance of bloody diarrhea, abdominal cramp, marked pallor, followed within three days by signs of peritoneal irritation and death. At necropsy a singular type of gastro-intestinal ulcer was found to be the immediate cause of these fatal symptoms. In one patient a solitary ulcer was found in the cardia of the stomach and several smaller ulcers in the jejunum, two of which had perforated; in the second patient there was a single perforating ulcer of the jejunum, in the third the same sort of lesion in the same portion of the gut, in the fourth a single ulcer of the duodenum, and in the last patient several large ulcers were found in the rectum.

It is noteworthy that the descriptions of these lesions were made by different regimes of pathologists at City Hospital but all commented upon the presence of hemorrhage about these erosions and all were impressed by the lack of induration and inflammation in the bordering tissues.

Gross inspection of the lesions reveals three features which appear to have a chronological relationship as shown in Figure I. The most common abnormalities are the irregular ecchymotic discolorations scattered over the surface of the mucosa. Less frequently there are found accumulations of blood in the shape of small hematomata, some as much as four mm. in diameter which are globular and elevate the mucosa in bleb-like fashion. Finally, in this setting are found the ulcers, limited by a clearly defined, non-indurated, discolored border.

A low power section through the intestinal wall where the ecchymoses and hematomata are most numerous discloses large cavities which are recognized as hugely distended veins in the mucosa and submucosa. In the loose tissues of this layer may be seen accumulations of red cells extending also into the muscle layer. The border of these ulcers is peculiarly free of inflammatory exudate, but in the serosal base of those which have not perforated there is evidence of an early fibrinous peritonitus.

Figure II is a section under higher magnification. There is a marked increase in the number and size of the fixed tissue endothelial cells but the most significant feature is the unusual ap-



Figure III. High power section through the base of one ulcer showing extensive proliferation of endothelial cells in a vein, almost obliterating the lumen. Some macrophages contain malarial pigment. One or two mitotic figures can be detected. Many smaller venules were completely filled with histiocytic cells.

pearance of the blood vessels in the submucosa and serosa. Capillaries, venules and arterioles are all occluded by plugs of round and elongated cells which are evidently the products of stimulated reticulo-endothelial activity. Some of these vessels appear to have desquamated the entire endothelial layer into the lumen. As shown in Figure III in some of the larger vessels the proliferation from the lining epithelium is clearly seen and a few mitotic figures are detected. Two or three larger cells contain malarial pigment and are recognized as blood macrophages. All of them are probably of the histiocytic type. Bruetsch[2] reports that such histiocytic stimulation is not very vigorous in the intestinal wall, except possibly in the outer or serous coat.

Whether or not the intravascular stimulation of the endothelial tissue to form large masses of macrophages can occur in such profusion as to occlude the venous return from portions of the intestines which are supplied by an end circulation, and to cause diapedesis, hematomata and ultimately necrotic, non-inflammatory ulceration is not clear, but in these cases this appears to be the only plausible explanation.

It is unlikely that a vascular cataclysm of this sort ever occurs in the cerebral circulation. Brosius[3] describes a case of cerebral malaria producing convulsions but offers no description of its pathology. Bruetsch[2] does not find a pronounced histiocytic reaction in the brain matter, although there are large numbers of such activated cells in the leptomeninges. Lehoczky[4] fails to find even this meager evidence of reticulo-endothelial stimulation in the brains of malarialized patients. From this it can be inferred that gross vascular lesions due directly to the effects of malaria are relatively rare in the brain tissue. Clinical experience seems to confirm this opinion. In the living patient who was under active treatment, focal symptoms of cerebral irritation or injury were found to be the exception rather than the rule if one excluded the toxic delirium occurring during the chill. Out of the 580 cases only two women had hemiplegic paralysis and this was of a transitory nature. Two patients had convulsions during the attacks where no convulsions occurred as symptoms of paresis itself, before the inoculation. One patient developed a slight unilateral facial weakness after the third chill, one complained of hemiparesthesia which persisted to some degree after seven months and one developed rigidity and bloody spinal fluid one week after the last malarial paroxysm and subsequently had a good remission. These findings are in no wise different from those in an equally large group of untreated paretics, for rarely is this disease subject to thrombosis, infarction and gummatous formations in the cerebral circulation.

Twenty-three brains were studied from patients who expired while undergoing the malarial treatment or within ten days after the last chill. Grossly, all these presented the orthodox findings of paresis, such as an increased amount of subarachnoid fluid, a cloudy, thickened pia, cortical atrophy, especially of the frontal poles and some dural adhesion. The surface of one brain was covered by a thin film of blood and another showed irregular patches of hemorrhage under the pia. On section one brain revealed several large areas of softening and this was regarded as Lissauer's form of paresis. Two of these brains were sectioned and a large number of blocks were studied, one of these being the specimen showing the subpial hemorrhages. No evidence of any cellular reaction which could be attributed to the malarial parasite and which would lead to some type of vascular accident could be demonstrated. As far as this brief investigation went, there was no proof that such a specific lesion as cerebral malaria exists, which can be set apart from the pathological picture of general paresis.

Rupture of the spleen as a grave complication in malarial therapy was first reported by Hermann[5] and occurs frequently enough to be given utmost consideration in the management of patients who are given this heroic treatment. The enlarged spleen which is generally found during and after the rigors is the best demonstration of the vigorous reaction of the hematopoetic system to the presence of the plasmodium of malaria in the blood. When one recalls that a large number of the patients become confused, delirious, and hyperactive, rough handling and excessive straining should be scrupulously avoided if one is to prevent this dire calamity. Bahr and Bruetsch[6] are of the opinion that a pré-existing morbid condition of this organ exists which makes it more susceptible to injury.

Tight restraint sheets across the abdomen, violent flexion of the body or a fall from bed as well as direct blows to the abdominal wall must be considered as immediate causes of rupture. One of the two patients in whom a ruptured spleen was found was seized with acute abdominal pain while walking to the washroom, and the other went into shock shortly after falling out of bed. The onset of symptoms was sudden, the patient in each case collapsed with signs of circulatory failure and shock, followed by rapid distention of the abdomen. In the first patient the peritoneal cavity contained about 3000 c.c. of bloody fluid and the laceration in the upper pole of the spleen was over three inches long. The capsule of the organ was not greatly thickened or hyalinized. In the second case the spontaneous rupture produced a large mass of clotted blood in the lesser peritoneal cavity and the tear measured about two inches in length.

If it is allowable to look upon malaria and syphilis as an antibiotic situation, symbiosis can also be demonstrated in the malarialized patient, for it is universally admitted that such a patient can succumb to many and various superimposed

infections such as cellulitis, pyelitis and bronchopneumonia. In one patient a mild cellulitis of the face rapidly developed into a rabid and fatal Ludwig's angina. Another interesting and unexpected complication was a gas gangrene infection. The portal of entry was never discovered but the autopsy revealed the classic picture of cutaneous emphysema and "foamy organs" while the blood culture was positive for Welch's bacillus.

Probably the most interesting demonstration of the amazing effect of malaria upon a latent infection was found in a forty-five year old negro who was admitted for the malarial inoculation because he had the clinical and laboratory signs of paresis. He was afebrile on admission, had no evidence of cardiac disease, had no subjective complaints and was well developed and well nourished. X-rays of the lungs were entirely negative and the heart shadow was within normal limits.

He was inoculated with five c. c. of malarial blood intravenously on September 25, 1933. Two days later the temperature rose to 39.6° C. and promptly dropped again to 37.4°C. For three consecutive days the temperature rose to a peak of 40° C., with a sharp drop between each elevation—a fever curve certainly showing no alarming modification. After the fourth day of rigors the temperature continued to range from 39° C. to 40° C., respiration became labored and rapid and the pulse rate was very high. The patient was delirious at times, complained of pain in the left chest, where a few rales were heard, and the neck became somewhat rigid. The patient expired on the fifteenth day following the malarial injection. Autopsy revealed a purulent pneumococcus meningitis, large fresh vegetations on the mitral, tricuspid and aortic valves, an acute fibrinous pleuritis over the left lung and several infarcts in the same organ. In this case an absolutely negative physical state within three days after malarial inoculation fulminated into such a rabid pneumococcus septicemia that one is led to believe that had not the plasmodium been introduced such a succession of events as occurred may have been prevented. These cases, however, are so few and far between that no secure conclusion can as yet be made.

SUMMARY

Malarial inoculation in the treatment of paresis may produce a wide array of symptoms and side actions which were responsible for a death rate of 12.7 per cent in a series of 580 treated cases. Hemorrhages, hematomata and non-inflammatory ulcers of the intestine may be said to be specific lesions due to malarial infection. Enlargement of the spleen is also a characteristic sign and a rupture of this organ may occur and result in immediate shock and death.

No specific lesion of malaria can be demonstrated in the brain tissues from a study of the material in 23 cases.

Rapidly fulminating septic states may apparently develop in otherwise normally resistant individuals after malaria is injected, suggesting a symbiotic relationship between the plasmodium and many pathogenic organisms.

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THE ADMINISTRATION OF OXYGEN BY INTRANASAL CATHETER*

By LOUIS E. BARRON, M.D., and GEORGE M. CURTIS, MD.,

COLUMBUS, OHIO

THIS paper claims no originality in describing the administration of oxygen by the intranasal catheter. Rather, by presenting an experience in its use, it emphasizes its simplicity, its efficiency, and its economy. The method described by Barach[1] in 1929, and used extensively by Wineland and Waters[2] and others, has, in our experience, produced highly satisfactory results. Its simplicity makes it available for use in the office, in the hospital, and even in the home.

The procedure consists in passing a nasal catheter, F. 10-12, through the nose, Figure I, until the tip lies opposite the uvula, Figure II. The catheter is then strapped to the face with adhesive, and connected to a trap-bottle, Figure III, containing water through which oxygen is bubbled. The water adds moisture to the oxygen, removes any water-soluble impurities, demonstrates the rate of flow, and maintains the desired temperature. The trap-bottle is connected to an oxygen cylinder by means of rubber tubing, Figure III. When the parts are assembled, a steady flow of oxygen can be administered with facility to the anoxemic patient.

Except in emergencies, we have used a large

*From the Departments of Surgery and of Medical and Surgical Research, Ohio State University.

tank of oxygen, to which is attached a flow meter, Figure III, A, which registers the rate of flow of oxygen passing through the system per minute. Wineland and Waters[2] maintain that the maximum concentration possible should be given at the outset, using the pulse rate as an indication of the influence of oxygen therapy. With a reduction of the pulse rate, the concentration of oxygen may be decreased. Potts[3] reports that any method which can supply a concentration of 30 per cent continuously and comfortably is of value, because 30 per cent to 35 per cent oxygen concentration usually lessens cyanosis and increases arterial oxygen saturation. Barach[1] has

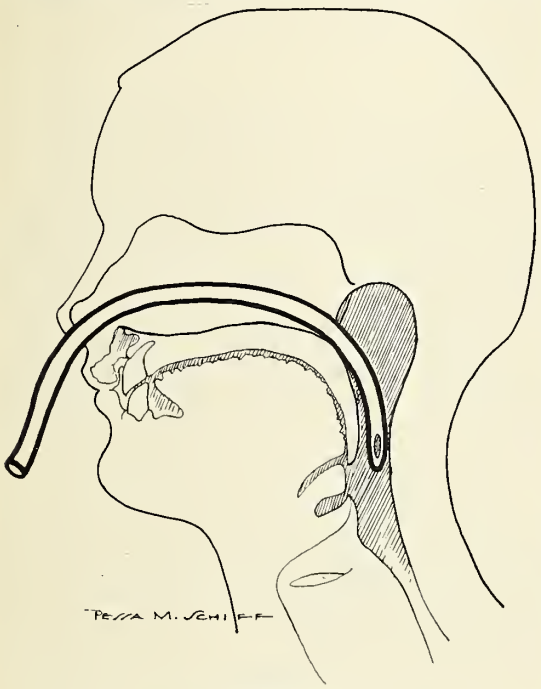


FIGURE I.
The position of the intranasal catheter.

shown that the concentration of oxygen may be raised to about 35 per cent by permitting five liters of oxygen per minute to flow through the nasal catheter. Wineland and Waters[2], however, demonstrated that when seven to eight liters of oxygen per minute pass through the catheter the concentration is well above 50 per cent. By further increasing the flow of oxygen, the concentration may be raised in excess of 70 per cent.

When oxygen is required in extreme haste, a small tank containing about 80 gallons, Figure III, may be used. The amount of oxygen which the patient receives is determined by observing directly the rate of bubbling in the trap-bottle. If the catheter is adequately lubricated and carefully inserted through the inferior meatus into the nose, and if the oxygen flow is properly adjusted, the patient experiences no discomfort. He is then able to follow his daily routine without the confinement of the oxygen tent, a condition which is greatly appreciated by the conscious patient.

The following cases, from the Research Service, illustrate the clinical occurrence of anoxemia. In the management of these, oxygen, by intranasal catheter, was used successfully:

CASE REPORTS

Case I. No. 334022. A white male, aged 30, with congenital hemolytic icterus, upon whom splenectomy was accomplished under gas-ether anesthesia, developed postoperative atelectasis. Air hunger and cyanosis rapidly developed. Twelve hours after operation the temperature rose to 104 F. and the pulse rate to 164 per minute. He also developed hiccough, as soon as postanesthetic consciousness was regained. The prognosis at this time seemed grave. Oxygen by intranasal catheter was instituted immediately. Carbon dioxide was given intermittently through the same catheter for the hiccough. Within 72 hours, all clinical evidence of the atelectasia disappeared, with the cessation of the hiccough. The patient subsequently made an uneventful convalescence.

Case II. No. 333998. A white male, aged 26, with right pulmonary tuberculosis of three years' duration, for which extrapleural thoracoplasty was performed, developed, postoperatively, severe respiratory and cardiac embarrasssment as a result of mediastinal shift. *X*-ray studies revealed that the patient had a minimal functioning aerating lung. His pulse rate rose to 160 per minute and his respiratory rate to 40 per minute. He was given oxygen by nasal catheter continuously for a period of two weeks, at the end of which time there was adequate vital capacity to take care of his respiratory requirements. He subsequently made a complete recovery.

Case III. No. 335092. A white housewife, aged 25, with severe exophthalmic goiter, for which subtotal thyroidectomy was performed, after adequate preparation, developed a postoperative reaction with evidence of ventricular dilation. Twelve hours after operation the temperature rose to 104 F., the pulse rate to 170 per minute, and the respirations to 40 per minute. Cyanosis, dyspnea, and mental disorientation supervened. Oxygen by nasal catheter was administered for about eight hours, at the end of which time all evidence of respiratory difficulty had disappeared.

Case IV. No. 334196. A white male, aged 53, with right pulmonary tuberculosis and a secondary dextro-cardia, for which thoracoplasty was performed, developed severe respiratory embarrassment as a result of mediastinal shift and diaphragmatic collapse following the removal of the 8th, 9th, 10th, and 11th ribs. His respirations were spasmodic, producing an inadequate exchange of gases. Cyanosis was evident. Oxygen was administered by nasal catheter with the prompt alleviation of the symptoms of anoxemia. Oxygen therapy was continued in this manner until there was a return of normal respirations.

Case V. No. 334673. This patient, a white girl, aged four and one-half, had congenital hemolytic icterus with a severe secondary anemia and a marked reticulocytosis. Her red blood count on admission to the hospital was 620,000. The

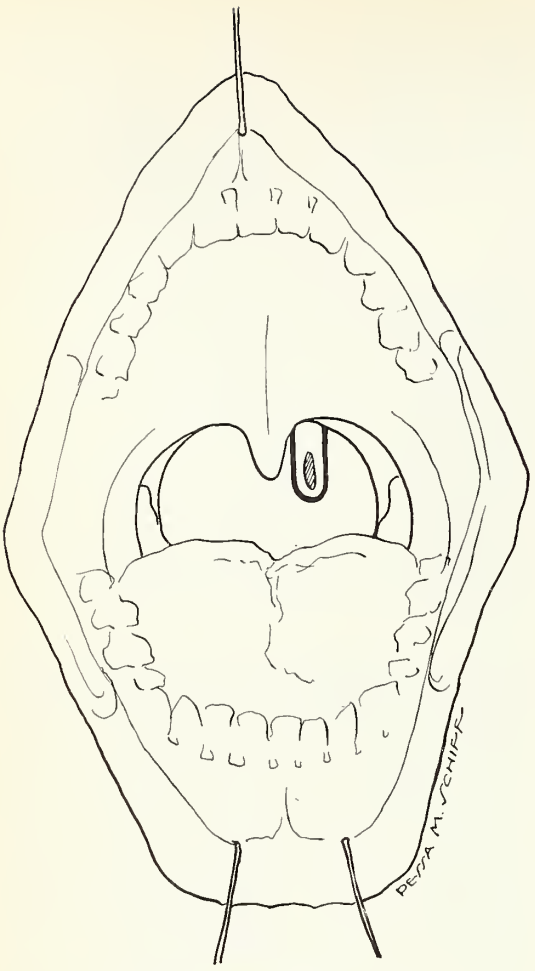


FIGURE II.
Relation of catheter to uvula.

hemoglobin was 2.6 grams by the Newcomer method. There were 92 per cent reticulocytes. Five days after admission she developed an acute, severe hemoclastic crisis for which immediate splenectomy was performed. Following the operation the patient became dyspneic and cyanotic. Oxygen by intranasal catheter was administered with the prompt relief of these distressing symptoms. Oxygen was given continuously for three days, at the end of which time the patient was able to resume normal respiration unaided.

Case VI. No. 334428. This case illustrates the ease and the speed with which oxygen therapy can be administered to a patient suffering from an acute anoxemia. The patient, a white housewife, aged 38, had left pulmonary tuberculosis for which thoracoplasty was performed. Ten days after the second stage operation, she developed sudden respiratory embarrassment. This was attributed to an acute anaphylactic reaction probably due to the absorption of tuberculo-proteins. The respiratory cycle became markedly disturbed by prolonged expiration, terminating in an expiratory grunt. The typical wheezing due to bronchiolar constriction was evident. Cyanosis developed and rapidly grew worse. A small tank of oxygen containing about 80 gallons was brought to the patient's room, and a nasal catheter was passed. The patient received oxygen five minutes after this emergency became evident, with the prompt disappearance of the cyanosis.

COMMENT

Tissue death is invariably due to diminished oxygen supply. Thus, Henderson[4] remarks that unless one is burned alive, the tissues of one's body always die of asphyxia. Therefore, it becomes vitally important to recognize anoxemia before irreparable tissue damage occurs. The recognition of early anoxemia may be exceedingly difficult, because of the body compensatory mechanisms which are brought into play during a state of oxygen want. It is only when these compensatory mechanisms become inadequate that the clinical appearance of anoxemia becomes evident.

Early anoxemia can be diagnosed by determining gasometrically the oxygen content of the blood. The method of analysis is difficult and is not readily applicable in everyday practice. However, Potts[3] predicts that the time will come when the determination of the blood oxygen will become as common a laboratory procedure for the diagnosis of anoxemia as the leucocyte count is for appendicitis.

A discussion of the morbid physiology of anoxemia is unnecessary, since this information is available in any standard text of physiology[5],

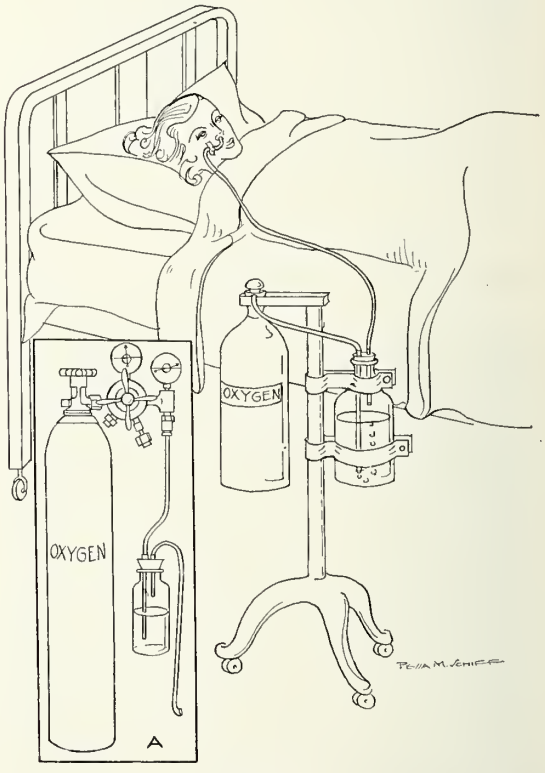


FIGURE III.
Patient receiving oxygen from a small tank which may be used for emergency purposes. Insert A, large tank assembled with flow-meter and trap-bottle.

and has recently been reviewed by Henderson[4]. Crisler and his associates [6] [7] [8] report that during anoxemia there is definite inhibition of gastric motility, and frequently a fall in the tone of the stomach. Under anoxemic conditions, laboratory animals may show a prolonged emptying time of the stomach.

From a clinical standpoint, the degree of cyanosis may be taken as an index of anoxemia. Cyanosis, when present, is usually observed in the lips and fingernails. However, other manifestations of oxygen want usually present themselves. If the anoxemia is sudden, consciousness may be lost without any prodromal symptoms. If the onset is gradual, cerebral clarity disappears, and the patient lapses into a state of unconsciousness which may be lethal if left uncorrected. Convulsions may supervene. The reason for this is thought to be due to the anoxic effects on the central nervous system.

Is oxygen in high concentration harmful to the anoxemic patient? Lavoisier[9] was one of the first to show, by animal experimentation, that the inhalation of oxygen produced congestion and inflammation of the lungs. Considerable investigative work led to similar conclusions[9] [10] [11]. However, the results of Regnault and Reiset[10] were not in agreement with those of Lavoisier. Barach[12] demonstrated that rabbits subjected to an oxygen concentration of 60 per cent for as long a period as two months, manifested no pathological findings. If subjected to a concentration of 80 per cent for four to fourteen days, the animals developed a pneumonia with marked pulmonary edema in spite of an attempt to increase the resistance of the pulmonary epithelium by exposing the animals at first to lower oxygen concentrations. Barach[12] therefore concludes that an oxygen concentration of 60 per cent is the threshold level.

Evans[13], in spite of the findings of previous investigators, administered pure oxygen by the face mask to more than 100 cyanotic patients for periods varying from one to twenty-seven days. The administration was made as nearly continuous as possible. He found that whereas pure oxygen administered to laboratory animals produced pulmonary edema, it produced beneficial results in patients suffering from pulmonary edema. He concludes that the early administration of pure oxygen in pneumonia is a potent factor in reducing the mortality rate. At the present time it is generally accepted that oxygen for the anoxemic patient in as high a concentration as possible is the desired therapy.

The most common methods of administering oxygen to the anoxemic patient are as follows:

1.) The oxygen chamber.
2.) The oxygen tent.
3.) The face mask.
4.) The funnel.
5.) The intranasal catheter.

The ideal method of administering oxygen is by means of the oxygen chamber. This provides an accurate and constant control of the oxygen percentage. The humidity of the atmosphere is also controlled. Adequate routine nursing and medical care can be performed here as in any other room. The sense of confinement, experienced in the oxygen tent, which the conscious patient resents, and which the semiconscious patient combats, is not encountered.

However, it must be recognized that the oxygen chamber is expensive, and because of this, is prohibited to many institutions. Thalheimer[14] estimates the cost of the oxygen chamber to be from $3,000 to $4,000. It requires much more oxygen than the oxygen tent or the intranasal catheter. An adequate staff of nurses, doctors, and technicians must be on hand at all times to rectify any technical inefficiency. Not only is the installation of the oxygen chamber expensive but its maintenance is cumbersome.

The oxygen tent has attained considerable popularity during the past few years. It is, obviously, less expensive than the oxygen chamber. That the tent can be installed over the bed of the patient is also of advantage. The tent requires less oxygen for its maintenance than the chamber.

There are, however, certain definite disadvantages to the oxygen tent. Patients complain of a sense of confinement. In the experience of many clinicians the restless patient is thrown into a stage of excitement, and the delirious patient becomes difficult to control. Because the tent is susceptible to leaks, it is difficult to maintain an oxygen concentration of 50 per cent. In the routine care of the patient, such as bathing and feeding, considerable oxygen is lost. It is difficult to control the temperature in the tent. The oxygen tent requires the constant supervision of someone with proper technical training.

The administration of oxygen by means of a properly adjusted face mask is an efficient method, but requires the constant supervision of someone to see that the face mask is adequately adjusted and held snugly against the face at all times. It has the advantage of permitting the administration of oxygen at any desired concentration.

The inefficiency of the funnel as a means of administering oxygen has long been recognized, and needs no further discussion.

The simplicity, efficiency, and economy of the intranasal catheter method makes it a desirable procedure in the treatment of anoxemia. In each of the instances reported above, the surgery was extensive and the ensuing anoxemia severe. The excitement, which is frequently seen

with the oxygen tent, would have superimposed another complication on a condition already grave. No difficulties are experienced in passing the catheter into the nasopharynx. Not only are the patients cognizant of the beneficial effects of this method, but they become apprehensive when, for some reason, the oxygen is discontinued and the catheter withdrawn. Routine medical and nursing care continue in normal fashion.

The catheter should be withdrawn at the end of twelve hours and inserted into the other nostril in order to prevent irritation of the mucous membrane. One should be cautioned against passing the catheter too far into the pharynx, since this increases the possibility of swallowing the oxygen, and of producing gastric distention. We have never encountered any evidence of pharyngeal irritation of sufficient magnitude to contraindicate the use of intranasal oxygen.

We have obtained such excellent results with this simple method of oxygen therapy that we have discarded the oxygen tent. The cases presented above illustrate severe post-operative anoxemia in the management of which the intranasal catheter method was used with success. This method of oxygen therapy can be used in anoxemic patients of all ages provided a catheter of proper dimensions is selected and the oxygen flow adequately adjusted.

In the majority of cases we have used the large cylinder containing 220 cubic feet of oxygen to which is attached a flow meter, Figure III, A, which regulates the minute amount of oxygen passing through the system. A minimum of five liters per minute should be given to the patient at the beginning of oxygen therapy. This can be increased or decreased, depending on the severity and duration of the anoxemia. In acute anoxemia we have used the small tank of oxygen containing about 80 gallons. The amount of oxygen passing through the system is estimated by observing the rate of flow through the trap-bottle.

SUMMARY

The administration of oxygen, by means of the nasal catheter, is a simple, economical, and efficient method of combating anoxemia. By means of the small tank of oxygen, this type of therapy, when indicated, can be rapidly instituted at the bedside of the patient, in the office, in the hospital, or even in the home.

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ASTHMA DUE TO BACTERIA: THE ATOPIC TYPE

By JONATHAN FORMAN, B.A., M.D.,

COLUMBUS, OHIO

IT IS now generally recognized that asthma is a manifestation of a specific hypersensitiveness induced after the tissues of the patient's body have been altered so that substances which are normally harmless affect the victim unfavorably producing the symptoms of asthma. Research has established that at least until we know more about the subject, we are to recognize four types of these altered reactions and that asthma may be a manifestation of at least three. (See Chart).

It is the purpose of this paper to emphasize the point that any patient who has inherited the capacity to be sensitized in a specific fashion to certain substances in the food or air upon adequate exposure, and to manifest this altered reactivity in the wind-pipe and its branches, may become sensitized in a like manner to the germs which he harbors in his body, and this change comes about regardless of whether the germs are disease producing ones or not. It does, however, seem reasonable to suppose that adequate exposure occurs more frequently in the fight against disease producing germs than it would with those bacteria which do not produce disease.

Because this paper presents little that is new, but much that is neglected—even by men specializing in this field—it will not be presented in an argumentative manner, but rather in a dogmatic fashion.

1. Bacteria may bring about an altered state in the body resulting in the production of the

Lecturer on Diseases Due to Allergy. College of Medicine of the Ohio State University.

CHART

Specific hypersensitiveness in the human is aptly termed *allergy (literally an altered state).*

1. Inheritance controlled allergy with a type of defense mechanism in the form of a special type of antibody known as Reagin. This is named Atopy (literally a strange disease). This includes specific sensitization to proteins of foods, inhalants, contactants, and bacteria.

2. *Bacterial Allergy*—is best represented by the altered state which is induced by the first infection with tuberculosis, after which the patient is always more susceptible to a second infection. This obtains for certain other types of bacteria.

3. *Contact Dermatitis*—In this condition, repeated contacts induce altered state and a high degree of sensitiveness may develop. Witness the patient who is poisoned by traces in the air of oleoresin, of the bruised plants and also of the poison ivy. Certain cases of asthma which are induced by the presence of plants in trillions of inorganic chemicals in the air.

4. *Serum Sickness*—That form of altered reactivity to foreign serum usually and almost universally induced by the second injection of a serum (N. B. Not a vaccine or extract out of a true serum).

symptoms called *asthma* in one of two ways: i.e., as a *bacterial allergy* or as an *atopy* (See Chart). It is the atopic form with which we are dealing in this paper.

2. There are four essential criteria by which an atopic constitution is determined. When all four are satisfied, it can be said positively that we have an atopy. If only three are satisfied, it is probable. If only two, it may possibly be such a condition.

These criteria are:

(a) A family history which reveals that the parents, grand-parents, uncles, brothers, sisters, or children have, or have had one or more of the following: Asthma, hayfever, coryza, nettle rash, hives, or bold hives, angioneurotic edema, eczema, mucous colitis, chronic recurring headaches, epilepsy, persistent recurring canker sores about the lips and mouth, or idosyncrasies to certain drugs.

(b) A personal history of one or more of the same as exhibited in the family history.

(c) The presence of more than 3 per cent eosinophilia in the blood during an attack.

(d) The presence of positive immediate reactions to skin tests.

3. When a patient with asthma is identified as a person having an altered constitution with an inheritance controlled capacity to become abnormally sensitive to specific substances in his surroundings, the best clue as to the possible offenders is to be obtained by properly performed skin tests for protein sensitization. We insist that in addition to the usual foods, contactants, and inhalants, intradermal tests with pure cultures of the common types of bacteria should be included routinely. These persons are usually abnormally sensitive to more than one substance and quite frequently they will be found to react to bacteria. Injections of the test material into, not under, the skin is the superior method of applying these tests. The amount injected should never exceed 0.02 c.c. In fact, an attempt should be made to use only 0.01 c.c. We use pure type vaccines containing one billion bacteria per cubic centimeter of:

Micrococcus Catarrhalis	Staphylococcus Aureus
Staphylococcus Albus	Streptococcus Hemolyticus
Streptococcus Viridans	Friedlander's Bacillus
Pneumococcus	B Coli

These may be obtained from one of the commercial houses specializing in vaccines. As has been said, we are not concerned in this paper with delayed reactions occurring in two to four days for those are tuberculin-like, and represent a *bacterial allergy.* This paper is limited to those reactions which occur within one hour, and which indicate an atopic reaction.

There need be no controversy about whether the physician should use a vaccine made by a commercial house or one made from the patient's own sputum. What is needed is knowledge as to what germs the patient is specifically sensitive, a vaccine of these bacteria, and their use in such a manner as to overcome the patient's abnormal reactions to the same germs. This can be accomplished in the most direct and satisfactory fashion by having at hand vaccines prepared from pure cultures of the various common bacteria, and using these for testing and treatment.

Well-marked positive skin reactions indicating the abnormal sensitiveness of inheritance controlled altered tissue reactions are characterized by the development of a hive at the point of the injection of the test material. They have a blanched elevated area of skin in the center around the site of the needle's entrance into the skin. Often they have irregular outlines with projections into the surrounding skin. Those who are familiar with false feet by which *amoeba* travel, have given the same name to these as these proturbances of the body mass of one-celled animals; i.e., pseudopods. To those who have never seen these false feet, the English name of spikes will better convey the idea of their appearance. These hives vary in size, but each is surrounded by a pink area due to an engorgement of the adjacent blood vessels.

The site of one of these positive reactions is hot to the touch and often itches or burns.

Positive skin tests to vaccines of pure cultures of organism which occur within an hour after the application, and which are characterized by the formation of a wheal as with those to foods and inhalants may represent past, present, or future trouble. The significance in the present attacks must be evaluated. This can be done by indirect testing.

4. Types of bacteria for whom Reagins can be demonstrated in the blood serum, *by indirect testing*, have clinical significance and must be given equal consideration with other positive atopens.

This indirect testing is performed as follows: The serum of the patient, collected under proper conditions of sterility, is injected *into* the skin of a normal person in the dosage of 0.05 c.c. One injection is made into a marked site for each of the positive immediate reactions obtained. In 48 hours after the reaction to the traumatism has subsided, an *intradermal* skin test is made at the site and about two inches to one side. This last acts as a control.

The reading of the indirect tests consists of a direct comparison of the reaction on the tested site with its control. A reaction is positive when there is an excess of reaction on the sensitized site, either in the size of the erythema, *or* wheal, or both. If the test at the site of the serum injection reacts positively, then it is certain that the atopic antibodies ("Reagins") are present in the patient's blood and these bacteria must be given consideration in the management of the case.

5. All possible foci must be searched for and if possible eradicated. In many instances this had better be accomplished after the patient has gained some tolerance to this by the use of vaccines as outlined in this paper.

It must be emphasized that we are not attempting immunization, but rather hyposensitization.

VACCINE SCHEDULE IN ATOPIC ASTHMA IN WHICH IMMEDIATE POSITIVE REACTIONS HAVE BEEN DEMONSTRATED

The point is to give many small doses gradually and carefully increased on a schedule patterned after that used with pollens, orris root, and other atopic excitants (atopens). While these injections must be individualized, the following schedule is followed in a general way: Equal portions of pure culture vaccines containing approximately one billion bacteria per c.c. are mixed.

It is essential that the dose be given accurately with a tuberculin syringe. This consumes considerable time and should not be embarked upon unless it is certain that these bacteria are specific trouble makers. Then it is only by such a procedure that a state of hyposensitiveness, a condition of allergic balance, or symptom relief can be obtained.

I. The intervals between these subcutaneous injections to be four days.

Injection No.	Amount
1	0.02 c. c.
2	0.04 c. c.
3	0.06 c. c.
4	0.08 c. c.
5	0.10 c. c.
6	0.12 c. c.
7	0.14 c. c.
8	0.16 c. c.
9	0.18 c. c.
10	0.20 c. c.

II. The interval between these subcutaneous injections to be one week.

Injection No.	Amount
11	0.22 c. c.
12	0.24 c. c.
13	0.26 c. c.
14	0.28 c. c.
15	0.30 c. c.
16	0.32 c. c.
17	0.34 c. c.
18	0.36 c. c.
19	0.38 c. c.
20	0.40 c. c.

II. The interval between these subcutaneous injections to be ten days.

Injection No.	Amount
21	0.42 c. c.
22	0.45 c. c.
23	0.47 c. c.
24	0.50 c.c .
25	0.55 c. c.
26	0.60 c. c.
27	0.65 c. c.
28	0.70 c. c.
29	0.75 c. c.
30	0.80 c. c.

IV. The interval between these subcutaneous injections to be two weeks.

Injection No.	Amount
31	0.85 c. c.
32	0.90 c. c.
33	0.95 c. c.
34	1.0 c. c.
35	1.0 c. c.

V. The intervals between these subcutaneous injections to be one month.

Injection No.	Amount
36	1.0 c. c.
37	1.0 c. c.
38	1.0 c. c.
39	1.0 c. c.
40	1.0 c. c.

SUMMARY

Do not fail to test with bacteria all atopic patients with asthma. Give equal consideration to the immediate reactions of bacteria as well as those with extracts of foods and inhalants. Produce a reasonable degree of tolerance before eradication of foci of infection. Then eradicate such foci and continue to give small doses of vaccine of the offending organism over a long period of time. This will solve certain cases of asthma in which the avoidance of the offending foods and inhalants have not given the relief expected.

394 EAST TOWN STREET.

REORGANIZATION OF MEDICAL DIVISION AND PROVISION FOR MEDICAL REVIEW BOARDS PROPOSED BY GOVERNOR'S COMMITTEE ON WORKMEN'S COMPENSATION

A NUMBER of the major recommendations of the Ohio State Medical Association for improving the administrative organization and operation of the Ohio Workmen's Compensation System are embodied and emphasized in the 52-page final report submitted to Former Governor George White shortly before the expiration of his term of office by the Governor's Investigating Committee on Workmen's Compensation. (February, 1935 issue *The Journal*, page 144).

The investigating committee was appointed by Governor White early in 1934 to study the operation of the Workmen's Compensation Law and recommend changes in the law and its administration. (March, 1934, issue *The Journal*, pages 171-173).

Personnel of the committee was: S. P. Bush, Columbus, chairman; Charles F. Michael, Bucyrus, president of the Ohio Manufacturers' Association; the late Warren F. Perry, Columbus, then secretary of the Ohio Manufacturers' Association; O. B. Chapman, Dayton, president of the Ohio State Federation of Labor and present State Director of Industrial Relations; and Thomas J. Donnelly, Columbus, secretary-treasurer of the Ohio State Federation of Labor.

TWO RECOMMENDATIONS COMPLIED WITH

Based on its earlier investigations, the committee formulated and submitted to Governor White a preliminary report recommending (1) the transfer of all personnel engaged in the administration of the Workmen's Compensation Law from the Department of Industrial Relations to the jurisdiction of the State Industrial Commission, with complete power and authority over such employes; and (2) a supplemental appropriation of $125,000 to the Commission to employ additional personnel for the under-manned de-departments responsible for the administration of the compensation law. (May, 1934, issue *The Journal*, pages 318-320).

Legislation in line with these recommendations was enacted at a special session of the General Assembly in May, 1934. (June, 1934, issue *The Journal*, page 387). Subsequently, the State Industrial Commission appointed Albert D. Caddell, Mansfield, an experienced executive, as secretary of the Commission, in charge of personnel and administrative details, and additional clerical personnel was employed. .

During the Summer of 1934, the investigating committee held public hearings in all important industrial sections of the state; took the testimony of hundreds of claimants, employers, physicians, attorneys and others, including officials and employes engaged in administration of the Workmen's Compensation Law; and employed a firm of consulting actuaries to make an actuarial survey of the State Insurance Fund and administrative procedure pertaining to financial matters.

The cooperation and advice of the Ohio State Medical Association was sought by the investigating committee. A special committee of the State Association conferred on several occasions with the investigating committee and subsequently submitted to the investigating committee several reports, including recommendations for changes in and improvement of the administrative procedure, based on studies of workmen's compensation problems made over a period of time by committees and officials of the State Medical Association. (May, 1934, issue *The Journal*, pages 318-320).

In its final report, the investigating committee expressed the belief "that the Ohio system of Workmen's Compensation can be made to operate successfully, but that the plan of administration and administrative procedure is in need of much reorganization in fundamental matters".

It was pointed out that one of the fundamental weaknesses of the system was corrected through the enactment of legislation transferring to the Industrial Commission complete control of all its employes.

COMMISSION OVERBURDENED WITH DETAILS

The committee found "the true and intended function of the Commission has been lost, or at least seriously impaired, because the Commission has been for a long time so overburdened with much detail that should be delegated to others that it has been unable to function as intended with the resources at its command".

"The original purpose of the law," the report stated, "contemplated that the Commission should have complete and thorough investigations made, developing all facts, should sit as a court, hear evidence, and pass judgment on the cases that come before it. For a long time this practice has not been followed, but instead, each commissioner has separately held hearings and subsequently recommended a judgment to the full Commission. Complete and thorough investigations have been impossible. This condition should be corrected and in another section your committee recommends reorganization and procedure

to make possible and practicable a return to the original and proper procedure."

DEPARTMENTAL PERSONNEL INADEQUATE

The committee pointed out what it believed were the reasons for much of the delay in handling claims and inefficiency in administrative details.

Inadequate personnel was blamed by the committee for some of the trouble confronting the Commission. To quote from the report:

"The number of payroll auditors is entirely inadequate in order to obtain results contemplated by the law, and in some cases their competency has been wholly lacking, and in others open to question. * * * The number of referees whose function is to conduct hearings and prepare cases for decisions is inadequate. * * The legal personnel required for workmen's compensation administration is inadequate. * * * The number of field workers engaged in investigating claims is wholly inadequate. * * * In some cases the qualifications of investigators and the investigations themselves are inadequate and unsatisfactory, involving serious delays, injustice, unnecessary expense, as well as handicaps to the Commission because of lack of evidence and facts that should have been determined immediately, fully and accurately, after occurrence of an injury. * * * From the happening of an accident to a decision by the Commission, the elapsed time has been far greater on the average than it should be, and determination of facts incident to the accident and subsequent medical examination are so inadequate and delayed as to cause great dissatisfaction on the part of claimants, prolonged delay in reaching conclusions, unnecessary litigation, serious injustice in some cases to the injured, and loss to the fund.

"The staff in the Department of Industrial Relations allocated to the work of administering the business of the Workmen's Compensation Law, particularly since 1921 and during the past few years, has not been of a character generally that would qualify for similar work in private companies. Improper selection, sometimes due to political influence, improper retention due to civil service, lack of business experience, inadequate pay due to mistaken policy, and inadequate appropriations have resulted in impoverishment of service and administrative efficiency.

"The office headquarters of the Commission and administrative staff are very unsatisfactory. Instead of the various divisions of the administrative staff being so that they are readily accessible and properly related one to the other, they are scattered in different parts of the State Office Building, in some cases with insufficient room for the work to be performed, and with inadequate and badly located space for the storage of records which must be frequently examined.

"Because of inadequate staff, many communications coming to the Commission are not only not promptly answered, but in some cases are not answered at all, and this has resulted in great dissatisfaction on the part of everyone concerned."

REHEARING CLAIMS A SERIOUS PROBLEM

The problems arising from the large accumulation of rehearing claims were discussed in the report, the committee making this observation:

"Your committee finds that as a result of the extensive unemployment during the past four years, while the number of new claims has diminished, the number of claims for rehearing, presented by those formerly injured, sometimes several years back in the case of claims for modification of awards, has greatly increased.

"This increase, it is believed, from circumstantial evidence, has been aided in many cases at least as a result of certain court decisions, and by the activities of members of the legal fraternity and others, in influencing some of those formerly injured and compensated, to appeal for modification of award, for rehearing and to file claims, and this procedure is facilitated by a system that has been in force within the jurisdiction of the Industrial Relations Department, Compensation Division, whereby the files of the Industrial Commission are made available to lawyers and others without sufficient evidence that such examination of files is proper, and not the result of collusion. This result has recently been corrected.

"We find at the present time there are nearly 4,000 of these rehearing claims pending, all of which must be prepared and heard upon the presumption that they may go to court, and which requires additional time, force and expense, also the setting up of reserves for these contingent liabilities.

"Also, while your committee has not been able to obtain definite proof, circumstantial evidence leads us to believe that there has been collusion between employes in key positions and representatives of claimants, whereby it is made possible for claimants' representatives to have cases formerly settled reopened, with the expectation that they may be ultimately taken into court, or that with the aid of those on the inside, a modification of award may be obtained. Also cases where applications for compensation by the claimant have been developed through collusion of employes of the Commission and subsequently allowed through the influence of an attorney or other agent."

The committee reported there are many small employers who are not contributing to the fund as a result of inadequacy and lack of qualifications of the personnel of the administrative staff; compliance with the Workmen's Compensation Law is not taken seriously by many employers and even some prosecuting attorneys; discrepancies in rate classification of employing units and premium rates have been found; the actuarial status and system are in need of revision; because of inadequate and unsatisfactory service there has gradually developed many service agencies given to the promotion of claims and to reduction of premium rates; employes and employers in increasing number are employing legal counsel, contrary to the intent of the Workmen's Compensation Law.

MEDICAL STAFF AND FACILITIES INADEQUATE

With respect to the medical staff and facilities of the Commission, the Committee said:

"The medical staff and facilities at headquarters are inadequate for thorough examination and the expeditious handling of the work, and your committee believes that in some cases the staff is lacking in qualification, and the present medical

system is seriously in need of revision to the end that prompt and adequate medical attention may be given claimants, and just and prompt settlement of claims may be had. The checking up of hospital cases, hospital services and charges, as well as doctors' services, has been inadequate.

"Your attention is especially directed to the fact that the cost of medical attendance and hospitals fees has been absorbing approximately one-third of the entire fund collected for compensation purposes, a very large sum, and attention is also especially directed to the state of the State Auditor in 1926 concerning excessive payments to physicians. Also it appears from complaints that we have received from physicians that some are being underpaid.

"Attention is directed to the fact that prior to 1932, the Auditing Department kept records of the payments to individual doctors, but that some time in 1932 the keeping of these records, which since 1921 were under the jurisdiction of the Industrial Relations Department, was abandoned. Your committee is of the opinion that no satisfactory excuse can be made for the abandonment of such important records."

QUALIFICATIONS OF COMMISSIONER DISCUSSED

As a preface to its recommendations for modification of the administrative organization and changes in the workmen's compensation statutes, the committee made the following observations regarding the qualifications and character of a member of the Industrial Commission:

"It may be said that the selection of well-qualified commissioners is of primary and vast importance, that all political consideration in making such appointments should be entirely eliminated, and that capacity and integrity alone should be the consideration. The intent and purpose of the original law, whereby each commissioner was to be appointed for a term of six years, was that it should be free from all political influence. Judicial temperament and judgment, and sympathetic regard for the injured without overstepping the bounds of justice are essential qualifications. In short, to be successful administrators of so important a responsibility, the commissioners should be big enough to rise above the sordid and political influences that are often brought to bear upon a body of this kind, and measure up to the best standards of the judiciary, and should be compensated accordingly. If the governor, who appoints, does not hold strictly to this view, and if the persons appointed do not measure up to these requirements, then it must be definitely admitted that the administration of Workmen's Compensation under the Ohio system can never be what it should be. If the service of a commissioner has been entirely satisfactory during his first term, he should be reappointed at the expiration of that term. Commissioners should be subject to trial and recall if found guilty of charges unbecoming to their office after a hearing in a court of justice.

"Commissioners cannot be expected to be experts in all of the administration detail of so vast and complex a business as the Ohio Insurance Fund, where experience and capable personnel is of vital importance.

"The character of the personnel of the Commission should be such that it is best qualified for the investigation and determination of claims, the determination of policy, general supervision, the establishment of regulations, and the enforcement of the provisions of the law which are specifically required of it.

"The committee is therefore very definitely of the opinion that the principal function of the Commission should be confined to these duties, and that all other functions should be under the direction of a manager especially qualified for the work, and subject to the general direction of the Commission. This manager should be selected and appointed by the Commission, from all applicants, subject to specifications outlined in detail, and requiring no less than five years of successful executive experience, a good general knowledge of the work, satisfactory character and temperament, and satisfactory references of previous service. Selection should not be confined to the State of Ohio."

DECENTRALIZED ORGANIZATION SUGGESTED

Recommendation No. 1 of the investigating committee was that the work of investigation and adjudication of claims should be decentralized, "in order to effect a prompt and thorough-going investigation of accidents resulting in injuries and to effect prompt and just consideration and settlement of claims".

The report summarized three proposed plans to accomplish this which had been considered by the committee, namely:

1. Increasing the membership of the Commission, the investigation and medical staffs.

2. Establishment of district boards of claims of commissioners each composed of three members, one representative of employes, one of employers, and one representative of the public, who would sit as a body to hear and finally determine the claims within the district, subject to appeals of the court under provisions of the law.

3. The setting up of 10 or 12 district headquarters, each in charge of a deputy commissioner operating under the direction of the Industrial Commission and provided with the necessary staff of investigators and medical personnel for the purposes of investigation, medical treatment, supervision, and who would hear and determine the claims within the district, subject to appeals to the Industrial Commission, and therefrom to the courts as provided by law.

With reference to the foregoing proposed set-ups, the committee said:

"After a very extensive consideration of these plans, and after conference with the Industrial Commission, your committee does not feel that any of these plans can be recommended at this time with a feeling of certainty that it would accomplish fully the desired ends. We therefore conclude that some trial of one or more of these plans is necessary in order to obtain experience on which to develop something that would be permanent."

FUNDAMENTAL PRINCIPLES SUMMARIZED

The committee emphasized that there are certain principles which are essential and must be observed in any plan of decentralization put into effect, namely:

1. All administrative functions and procedure

must be subject to the central authority of the Industrial Commission.

2. The Industrial Commission should sit as a body and no less than three should hear and determine all claims involving special consideration, such as controversial and involved claims.

3. Whenever practical, hearings should be held at points reasonably convenient to the claimants.

4. Investigation of accidents should be thorough and prompt.

5. Medical attendance upon the injured should be prompt and thorough; regular and competent examination of the injured and supervision of treatment should be assured.

6. Claims should be adjudicated promptly.

REORGANIZATION OF MEDICAL DIVISION

Recommendation No. 2 pertained to proposed reorganization of the medical division of the Commission, as follows:

"As a result of our investigation and the experience of your committee, it appears that in at least 80 per cent of the injured cases, compensation or non-compensation depends upon medical judgment, which obviously should be as competent and sound as possible. As the Commission itself cannot be expected to form judgments concerning the proper treatment of injuries, nor to determine the disabilities or the extent of disabilities arising out of injuries without expert assistance, your committee is of the opinion that the Commission is in need of a highly competent medical chief, a man not specialized in one line or another, but one of wide general experience, of high character, having executive capacity and temperamentally qualified to deal fairly and efficiently with the medical fraternity in general. He should be qualified to conduct or have conducted, researches concerning occupational disease and other disabilities, and to organize and direct the entire medical personnel and procedure under the general direction of the Commission. He should be qualified and have the power to select, with the approval of the Commission, all other members of the medical staff regularly employed and others who may be selected from time to time as specialists for the purpose of special examinations. He should be employed by and subject to removal by the Industrial Commission, and should be paid enough to warrant his leaving his private practice.

SHOULD HAVE GREATER AUTHORITY

"The chief medical officer should direct and supervise hospitalization and rehabilitation. He should be held accountable for prompt and proper medical examination of the injured, for the competency and efficiency of the staff, and for the economical though thorough operation in general of the medical division. With the approval of the Industrial Commission he should have the power to dismiss medical members of his staff. Your committee cannot emphasize too strongly the importance of this position in the matter of doing justice to the injured, avoiding delays and appeals, and saving a great deal of expense to the fund."

MEDICAL REVIEW BOARDS NEEDED

Recommendation No. 3 incorporated one of the principal recommendations of the Ohio State Medical Association, namely that medical boards of review be established by the Industrial Commission on a district basis to review and pass on chronic, prolonged, unusual or revived cases and submit findings to the Commission upon which adjudication of such claims could be based.

This part of the report was in part as follows:

"In the course of our investigation we have found that in the case of both self-insurers and subscribers to the fund, medical examination and treatment have often been inadequate, sometimes improper, and that in many important cases the Commission has rendered judgment either favorably or unfavorably, predicated upon the judgment of one medical man selected as an expert and specialist for a particular case. It has happened often that an injured employe developing disability subsequent to the accident, has been examined separately, often by three, four or five physicians, and in one case by seven, with little agreement in diagnosis and no relief afforded from treatment. Also some cases have been disallowed where injury was the cause of disability, and in other cases the claim of disability from injury was allowed without foundation in fact. Out of such conditions there arises much dissatisfaction on the part of claimants, frequent requests for examinations and rehearings, medical treatment, and court litigation, all of which involves delay and expense with little satisfactory result.

"An injured worker may be attended by a doctor selected by his employer, or by his own doctor. In either case there has been no immediate and satisfactory check upon the treatment and upon the thoroughness of the examination. Also where the injured is taken to the hospital, the follow-up of the case in the hospital has been either neglected entirely or has been wholly inadequate. Such check-up is necessary in the interest of the worker, the employer, and the fund. Therefore, the necessity of there being attached to the staff in various parts of the state competent medical men for the purpose of following up and checking up, and reporting facts and evidence accurately. Such procedure would prevent or shorten disability in many cases, would restore the worker more promptly to work, would avoid many subsequent disputes, and save expense to the worker, the employer, and the fund.

EXISTING DIFFICULTIES CITED

"In many cases where there is a difference of opinion between the attending physician and the Commission's doctor, or in many cases where it is difficult to determine disability or the extent of disability, or in some cases where disability may or may not be attributed to an original injury, there is often serious differences of opinion and fair judgment becomes difficult or questionable under present procedure. This results many times in delay, dissatisfaction and court appeals. It is the opinion of your committee that in such and similar cases the judgment of one man is inadequate, and that instead, there should be appointed by the chief medical officer, from within any given district, when practicable, a medical board of review for each case, comprised of three of the most competent experts to be found, men whose standing in the profession is beyond question, and whose judgment would constitute the best that is available, and make possible a fair and final determination of fact, subject always to a re-examination in the event of new developments or undiscovered elements. Such procedure would constitute the best that could be provided,

and, on the testimony of many injured complainants would be regarded as entirely satisfactory to them.

"Your committee cannot emphasize too strongly the importance of such a medical organization and procedure as is here recommended. One of the purposes of the Compensation Law was that there should be a determination of facts as complete as possible to the end that the judgment of the Commission may be as fair and conclusive as possible under the law; consequently it must be clear that such a procedure as has been here outlined is necessary.

AIDED BY STATE MEDICAL ASSOCIATION

"In connection with the medical factor and medical organization, your committee has conferred with the Ohio State Medical Association and individual doctors for suggestions. The Ohio State Medical Association appointed a special committee to make a report on the general subject of medical organization for the particular work of dealing with industrial injuries and recommends, with much emphasis, the necessity of medical boards of review, and a more thoroughgoing administration of the medical department. The organization of a medical department below that of the chief medical officer must necessarily be the duty of the Commission to determine, and in what way it shall provide for medical boards of review. This report of the Ohio State Medical Association in general, however, is in line with the views of your committee, and confirms many of the committee's findings.

"Such an administrative organization and procedure would, in the judgment of your committee, result in far greater justice, avoid great delay, save expense, and under proper rules set forth in the law, would eliminate much litigation.

"First aid, medical and hospital service provided by self-insurers should be subject to inspection and approval by the chief medical officer of the Commission."

REHABILITATION AND HOSPITALIZATION

Recommendations 3 and 4 dealt with the subjects of rehabilitation and hospitalization, respectively.

The committee reported that physical rehabilitation has not been given the attention that it should have and that facilities for effecting physical rehabilitation are inadequate. It was recommended that a rehabilitation bureau should be organized under the medical branch of the Commission and an adequate rehabilitation fund set up, "to the end that in several parts of the state the injured may be adequately cared for".

The committee expressed the belief "that at some point or points in the state the medical department should either have facilities of its own or a section of some hospital allocated to it under contract whereby the medical department can have special cases under its constant and immediate observation and treatment".

Recommendation No. 5 suggested that the accident prevention department of the Industrial Commission be built up and maintained at the highest state of efficiency possible.

Recommendation No. 6 pointed out that the committee believes very definitely "that essential check-ups should be provided by an advisory council made up of the representatives of those special interests in addition to and apart from the Commission, at least two of which should represent labor, a like number of employers, and one a neutral member, who should be considered as representing the public and acts as chairman".

Under the suggested plan, the Industrial Commission would be required to appoint such an advisory council from nominations made by statewide representative organization of employers and of labor, the fifth member to be selected and appointed by the Industrial Commission as a representative of the public. Such advisory council would be required to report to the Commission its views and recommendations not less than twice a year; to the Governor if requested by him to do so; to check up on administrative procedure, fiscal affairs, etc., and assist the Commission on matters of policy and procedure.

SALARY ADJUSTMENTS RECOMMENDED

Recommendation No. 7 emphasized that the major and more important personnel of the Commission has been much under-paid; that this situation must be corrected; and that salaries must be such as to make it possible to obtain the competence and quality necessary for the administration of highly important insurance business.

The report stated many of the most capable employes have left the service to engage in private business, such as service agencies, etc., and "this has been a contributing factor to inefficient and deficient service".

"Such an institution should hold out an opportunity for a career for men and women comparable in capacity and otherwise, with that of private business," it stated. "Some of the medical staff have found it necessary to conduct private practice in the evenings, and in other divisions the lack of fair compensation has undoubtedly been a contributing cause of irregular practice and promotive of dishonesty."

It was suggested that salaries should be determined by a joint committee composed of the chairman of the Industrial Commission and the advisory council upon suggestions of the manager.

CHANGE IN CIVIL SERVICE RULES URGED

Recommendation No. 8 pertained to the civil service laws in relation to the administrative staff of the Commission.

The advantages and desirability of the civil service principle are recognized, the committee said, yet the existing civil service regulations require modification if a satisfactory administrative personnel is to be had for the Ohio Workmen's Compensation System.

In brief, the committee recommendations were: The power to suspend, and the power to discharge employes should lie with the Industrial Commis-

sion. The opportunities for appeal, in cases of discharge, should be provided and hearings on appeals should be held jointly by the Civil Service Commission and two members of the advisory council, their decision being final. The Industrial Commission and its manager should have the power to make selections of all those requiring special training from a list of prospects answering newspaper advertisements. Those selected should be certified to the Civil Service Commission for the purpose of protecting but not selecting the appointee. All subordinate personnel should be subject to examination by the Civil Service Commission and selections made from the first five meeting the specifications approved by the Industrial Commission. Provision should be made whereby promotion among the subordinate personnel may be had through civil service examination in the regular way; and in all other cases with the approval of the Industrial Commission after recommendation by the manager.

SUGGESTIONS FOR LEGISLATIVE ACTION

Recommendation No. 9 incorporated the following suggested statutory amendments:

1. To give the Industrial Commission authority to appoint medical boards of review.

2. To provide that physicians, who in the course of their professional duty furnish medical information in reports covering any case to the Industrial Commission, shall be given immunity from prosecution.

3. To give the Industrial Commission authority to provide special hospital and physical rehabilitation facilities for the observation and treatment of special cases.

4. To make mandatory the appointment of an advisory council to the Industrial Commission.

5. To make provision whereby employes may be selected by the Industrial Commission or its deputy, and promoted, suspended and dismissed by the Industrial Commission.

NEED FOR MORE FUNDS EMPHASIZED

Recommendation No. 10 advocated substantial increases in the administrative budget of the Industrial Commission.

"The appropriations made by the Legislature for the administration of the Compensation Law have been less than half of what they should be, and your committee regards it as not only impractical but impossible to successfully operate a great institution with such inadequate administrative funds," the report declared.

The actuarial survey, made by Woodward and Fondiller, Inc., New York City, and issued as a supplement to the committee's report, contained numerous recommendations for changes in the administrative procedure in connection with financial matters, investments, records, investigations, actuarial questions, personnel, etc.

Attorney General Renders Opinion on Quarantine of All Dogs

Holding that a local board of health not only has power to require immunization of all dogs against rabies, but that it has authority to require the quarantine of all dogs which have not been so immunized when there is a prevalence of rabies, the Attorney General in Opinion No. 3894 recently issued cited Section 5632-16 of the General Code, reading as follows:

"Whenever in the judgment of any city or general health district board of health, or person or persons performing the duties of a board of health, rabies shall be declared to be prevalent, such board of health, or person or persons performing the duties of such board of health, shall declare a quarantine of all dogs in such health district, or part thereof. The quarantine so declared shall consist of the confinement of any dog or dogs on the premises of the owner or in a suitable pound or kennel if a pound or kennel is provided by the city or county; provided, a dog may be permitted to leave the premises of the owner if under leash or under the control of the owner or other responsible person. The quarantine order herein authorized shall be considered an emergency and need not be published.

"When a quarantine of dogs has been declared in any health district, or part thereof, it shall be the duty of the dog warden and all other persons having the authority of police officers to assist the health authorities in enforcing the provisions of the quarantine order.

"The penalty for the violation of the rabies quarantine order shall be the same as provided for the violation of other orders or regulations of the board of health."

In connection with the opinion, the Attorney General cited the case of Ex Parte Mabel Mason, 22 O. N. P., in part as follows:

"Section 1237 heretofore referred to which fixes the general powers and duties of the state board of health gives such board and its successor, in matters pertaining to the prevention of the spread of contagious and infectious diseases and quarantine, as broad powers as could be well granted. While the term with reference to quarantine 'supreme authority' is used, that must be understood as meaning supreme legal discretion or authority and not arbitrary power."

The conclusion of the opinion reads as follows:

"In view of the foregoing, if the board of health has power to require the immunization of all dogs against rabies it follows that such board has authority to require the quarantine of all dogs, which have not been so immunized, in the district or part thereof under its jurisdiction, when a prevalence of rabies has been declared therein.

"Your question of whether or not such quarantine may be declared for a period of six months or a year, is answered by the plain language of the statute which conveys a clear and definite meaning, to-wit, that a city or general health district board of health may quarantine all dogs when in its judgment rabies are declared prevalent. In other words, any such board of health may, when in its judgment rabies are declared prevalent, declare a quarantine of all dogs not immunized until such time when such epidemic no longer exists, at which time such quarantine should be lifted."

SALES TAX REGULATIONS APPLYING TO PHYSICIANS REVISED AND CLARIFIED

AS pointed out in the article published in the February *Journal*, rulings by the State Tax Commission classified physicians as "consumers" rather than "vendors" under the sales tax law, thus relieving physicians of the responsibility and red-tape of taking out vendors' licenses and becoming tax collectors.

A special ruling known as Special Ruling No. 7 (revised) applying to sales to and by physicians and which is the latest official interpretation on the subject issued by the State Tax Commission, reads as follows:

> "A physician for the purpose of Amended House Bill No. 134, is the consumer of the various articles which he uses in connection with the rendition of his professional services and is required to pay the tax when purchasing such items. He is also required to pay the tax on all equipment, appliances, medicines, etc., when purchased by him, without regard as to whether the charge is in a lump sum or is made up of items representing materials and services.
>
> "The tax does not attach on the fee for professional services rendered by the physician which include the utilization of various tangible articles as an incident to his professional practice where such tax has already been paid on these articles by the physician when purchased.
>
> "*If* a physician is engaged in *selling to the public* medicinal supplies or other tangible personal property not in connection with his examination or professional service to a patient, he is a vendor within the meaning of the act, must procure a vendor's license and collect the tax on all such sales in the manner prescribed by Section 3 of the act."

PROFESSIONAL SERVICE EXEMPTION

These regulations are based on two of the *general exemptions* incorporated in the sales tax statute reading as follows: **"Casual and isolated sales by a vendor who is not engaged in the business of selling tangible personal property"** and **"professional or personal service transactions which involve sales as inconsequential elements for which no separate charges are made".**

Therefore, under the terms of the law and the regulations of the Tax Commission, a physician in his professional practice may dispense drugs, appliances, etc., without becoming a vendor or tax collector, provided such dispensing is incidental to his professional service and further provided that **no separate charges are made for such tangible materials.**

As a further interpretation on this regulation, the Tax Commission has held that where a physician is actively engaged in dispensing medicinal supplies or selling articles of tangible personal property **not directly in connection with his examination or professional service,** he is a "vendor" within the meaning of the act, must procure a

WHY BE A VENDOR?

Apparently through misunderstanding or through misconstruction of the Ohio Sales Tax Law and the regulations of the Tax Commission, a number of physicians in various sections of Ohio have secured vendors' licenses, according to information received.

Evidently representatives of some of the drug concerns have misled physicians into believing that by becoming "vendors", physicians would not be required to pay a sales tax on medicine, equipment, etc., and would not be required to collect taxes from their patients.

It should be understood that if a physician secures a vendor's license and so records himself with the Tax Commission, he becomes a "tax collector", must keep records, make accountings, secure and distribute sales tax coupons to those to whom he sells tangible personal property, presumably including drugs. On the other hand, if physicians are classed as "consumers", as contemplated under the regulations, they need *not* become vendors and tax collectors.

Previous analysis of the sales tax as it applies to physicians was carried in the January *Journal*, page 43, the February *Journal*, page 128, and through special bulletins to the secretaries and legislative committeemen.

If physicians procure vendors' licenses, they may complicate the situation in tax administration and precipitate regulations burdensome on the profession generally.

Attention is called to the accompanying article and the only instance in which physicians are construed as vendors—when eye glasses are furnished direct to patients.

vendor's license and collect the sales tax on all sales in the manner prescribed in the statutes.

The new and revised regulations further substantiate the three points set forth in the article on this subject in the February *Journal*, pages 128 and 129, as follows:

1. That the sales tax law does not contemplate the inclusion of professions or professional service under the broad definition of "The business of selling tangible personal property at retail".
2. That under the exemptions secured in the law, physicians may dispense drugs and other appliances to their patients without collecting a sales tax where no separate charge is made by the physician to his patient for such tangible articles.
3. That in view of the fact that the sales tax, under the broad terms of the law, is expected to be collected somewhere along the line, physicians should be classed as "consumers" rather than as "sellers" and, therefore, they would be required to pay the sales tax on their medicines, equipment and appliances when they are purchased from the druggist, jobber or other source.

In connection with its interpretation of the sales tax as applied to pharmacists and druggists, Special Ruling No. 1, entitled "Sales of Medicine and Compounds on Prescription by Pharmacists", reads as follows:

> "Sales of medicine or compounds on prescriptions when such sales are made by pharmacists or druggists are subject to the tax imposed by Amended House Bill No. 134. The tax is to be computed on the entire selling price of the article so sold and no deduction may be made for the professional services which enter into the making of the finished article."

RULING ON EYE GLASSES

In relation to the sale of eye glasses, Special Ruling No. 5, entitled *Sales of Glasses by Opticians, Oculists or Optometrists*, reads as follows:

> "An optician, oculist, or optometrist engaged in selling eye glasses in connection with his services is a vendor within the meaning of Amended House Bill No. 134 and as such must procure a vendor's license and collect the tax on all sales.
>
> "The tax basis will be the selling price of the eye glasses without any deduction being made from that price as a charge for the services which enter into the making of the finished product.
>
> "In the event charges for professional services or examinations which are rendered apart from the making of said eye glasses are itemized separately, the tax will not be computed thereon."

Efforts are being made at the present time to secure a modification or clarification in the foregoing ruling to permit physician oculists to pay a sales tax to the manufacturing optician to whom he sends a prescription and from whom he gets glasses to furnish to his patient, and to be relieved of the necessity of becoming a vendor and tax collector in connection with the dispensing of glasses. Representatives of the State Association have pointed out that where a physician makes an eye examination, has glasses constructed in accordance with his definite and individual specifications applying to an individual patient and where he has such glasses sent to him for adjusting, testing and fitting to such patients and where he makes a lump sum charge to the patient for his professional service, including furnishing of glasses, that he is actually rendering professional service rather than "selling tangible property" and that he should *not* be required to make a separate charge and collect a sales tax on the price of the glasses, particularly if he should pay a sales tax to the manufacturer or optician who constructs the glasses according to his specifications.

However, at the present time and until or unless there is a modification in this ruling, it means that where a physician dispenses glasses and makes a separate charge for such glasses, that a tax must be collected on their sale and that such physician in that instance and to that extent is classed as a retailer, required to secure a vendor's license and to collect the sales tax from his patient.

PROFESSIONAL SERVICES NOT TAXABLE

It will be seen by the interpretation that doctors' fees for professional services are not to be subject to the sales tax. However, where physicians *sell to the public* drugs, biologicals, surgical dressings, splints, eye glasses, braces or other merchandise, entirely aside from professional service, they are required to collect a charge of 3 per cent sales tax on the selling price.

Under the definition of the practice of medicine, it is contemplated that a physician, as a part of professional service and as a part of his professional fee, may prescribe or dispense drugs and appliances without being construed as a dealer in tangible commodities.

In an opinion (No. 3849) issued by the Attorney General, he points out in part as follows:

> "'Sale' and 'selling' include all transactions whereby title or possession, or both, of tangible personal property, is or is to be transferred, or a license to use or consume tangible personal property is granted, for a consideration in any manner, whether absolutely or conditionally, whether for a price or rental, in money or by exchange or barter, and by any means whatsoever.
>
> "'Vendor' means the person by whom the transfer effected or license given by a sale is or is to be made or given; and in case two or more

persons shall be engaged in business in the same *retail establishment* under a single trade name in which all collections on account of sales by each are made, such persons shall constitute a single vendor for the purposes of this act. ***

" 'Retail sale' and 'sale at retail' include all sales excepting those in which the purpose of the consumer is (a) to re-sell the thing transferred in the form in which the same is, or is to be, received by him; or (b) to incorporate the thing transferred as a material or a part, into tangible personal property to be produced for sale by manufacturing, assembling, processing or refining, or to use or consume the thing transferred in manufacturing, retailing, processing or refining or in the rendition of a public utility service; or (c) security for the performance of an obligation by the vendor. ***

" 'Retail establishment' means any premises in which the business of selling tangible property is conducted or in or from which any retail sales are made. ****

" 'For the purpose of the proper administration of this act and to prevent the evasion of the tax hereby levied, it shall be presumed that all sales made in this state during the period defined in this section are subject to the tax hereby levied until the contrary is established.' ****

"It appears however, by the terms of Section 10 of the Retail Sales Act (Sec. 5546-10 G. C.), that *it is not the intent of the law to tax retail sales except those that are made by persons engaged in making such sales as a business.*"

RULINGS ON HOSPITALS

In relation to sales to and by charitable hospitals, Special Ruling No. 37 reads as follows:

Sales to Charitable Hospitals

Sales of the following items, made to charitable hospitals, are construed to be sales for the purpose of resale where purchased by charitable hospitals and the tax levied by Section 2 of Amended House Bill No. 134 does not apply:

Drugs and Chemicals

To be used within the hospital or distributed to patients being treated in the out-patient department and clinics.

Anaesthesia Department

Ether
Chloroform
Anaesthesia gases

Professional Supplies

Adhesive
Surgical cotton
Cellu Cotton products
Gauze and bandages
Sutur material
Plaster Paris
Stockinette
Sheet wadding
Crinoline
Sputum cups
X-ray films and supplies
Laboratory supplies
Orthopedic appliances
Dental supplies

Food

Sales of the following items are construed to be sales for purposes of consumption by the hospitals and the tax imposed by Section 2 of Amended House Bill No. 134 applies thereto:

Furnishings

Beds
Equipment

Office

Printing & Stationery
Office supplies

Housekeeping Dept.

Bedding
Linens
Sheets
Pillow cases
Blankets
Brooms
Brushes
Soap
Cleaning Powder

Building Material

Repairs for building or equipment

Uniforms

Internes
Nurses
Operating gowns
Patients gowns
Surgeons gowns

Training School

Office supplies
Books for nurses

Store Room Items

Cooking utensils
Enamelware
Glassware
Dishes
Surgical instruments
Rubber goods
(a) sheeting
(b) gloves
(c) tubing
Toilet soap
Silverware

Engineering Dept.

Coal
Oil
Electric light bulbs

SPECIAL RULING NO. 38

Sales Made by Charitable Hospitals

A charitable hospital is a hospital which is organized not for profit and which regularly engages in administering to patients who are unable to pay for the services rendered them by the hospital and who do not in fact make payment to the hospital. Sales made by such hospitals are not subject to the tax imposed by Section 2 of Amended House Bill No. 134, as they are charitable organizations within the exemption set forth in sub-paragraph 10 of said section.

—OSMJ—

New Books

Hughes' Practice of Medicine. Revised and edited by Burgess Gordon, M.D. With sections on Nervous and Mental Diseases, by Harold D. Palmer, M.D., and on Diseases of the Skin, by Vaughn C. Garner, M.D. Fifteenth edition, with 61 illustrations. Flexible fabrikoid, $5.00. P. Blakiston's Son and Company, Inc., Philadelphia, publishers.

Elementary Human Anatomy. Based on Laboratory Studies. By Katharine Sibley, Professor of Physical Education, School of Education, Syracuse University, Syracuse, New York. Cloth binding, 380 pages with 213 illustrations. Price $4.50. A. S. Barnes and Company, Publishers, 67 West 44th Street, New York.

Observations of a General Practitioner, by William N. Macartney, M.D.; not a text-book but a record of the personal observations and deductions of the author, a general practitioner and family doctor, boasting of a long and arduous experience in private practice; Richard G. Badger, publisher, The Gorham Press, 100 Charles Street, Boston.

POLICIES ON PENDING SICKNESS INSURANCE PROPOSALS ADOPTED AT SPECIAL SESSION OF A. M. A. HOUSE OF DELEGATES

A DEFINITE pronouncement, supplementing existing policies, to guide organized medicine in meeting current serious problems arising from pending and proposed legislation relating to sickness insurance and other social, economic and governmental questions affecting public health and medical practice, was adopted by the House of Delegates of the American Medical Association, meeting in special session in Chicago, February 15 and 16, 1935.

Through adoption of various recommendations made by a Special Reference Committee following prolonged discussion, the House of Delegates of the American Medical Association laid down the following policies:

1. Believing that regimentation of the medical profession and lay control of medical practice will be fatal to medical progress and inevitably lower the quality of medical service now available, organized medicine "condemns unreservedly all propaganda, legislation and political manipulation leading to these ends".

2. Organized medicine reaffirms its opposition to all forms of compulsory sickness insurance whether administered by the Federal government, the governments of the individual states or by any individual industry, community or similar body.

3. It encourages local medical organizations to establish plans for the provision of adequate medical service to all of the people, adjusted to present economic conditions, by voluntary budgeting to meet the costs of illness.

4. Organized medicine recognizes the necessity under conditions of emergency for Federal aid in meeting basic needs of the indigent, but it deprecates any provision whereby Federal subsidies for medical services are administered and controlled by a lay bureau.

5. Organized medicine recognizes "the fact there is no model plan which is a cure-all for the social ills any more than there is a panacea for the physical ills that affect mankind".

6. Plans developed locally by county medical societies should be based on the ten fundamental principles adopted by the House of Delegates of the American Medical Association in June, 1934.

7. The Board of Trustees and Bureau of Medical Economics of the A.M.A. should study further the plans now existing and such as may develop, and develop for presentation at the meeting of the American Medical Association in June, model skeleton plans adapted to the needs of populations of various types.

The report adopted by the House of Delegates emphasized that the American Medical Association is the largest medical organization in this country; the only medical organization open to all reputable physicians and established on truly democratic principles; and the House of Delegates of which is the only body truly representative of the medical profession.

The Board of Trustees and the officers of the A.M.A. were commended "for their efforts in presenting correctly, maintaining and promoting the policies and principles heretofore established by this body".

With respect to the preliminary report recently submitted to Congress by the Committee on Economic Security, the report approved by the House of Delegates said:

"The House of Delegates is glad to recognize that some of the fundamental considerations for an adequate, reliable and safe medical service established by the medical profession through years of experience in medical practice are found by the Committee (i.e., Committee on Economic Security) to be essential to its own plans.

"However, so many inconsistencies and incompatabilities are apparent in the report . . . that many more facts and details are necessary for a proper consideration."

The so-called Epstein sickness insurance bill, proposed by the American Association for Social Security for introduction in state legislatures, was condemned as "a vicious, deceptive, dangerous and demoralizing measure" and "introduces such hazardous principles as multiple taxation, inordinate costs, extravagant administration and an inevitable trend toward special and financial bankruptcy".

CARE OF POOR GOVERNMENT DUTY

The House of Delegates definitely recognized the allocation of Federal funds to the various states to provide medical care for the indigent under emergency conditions but as distinguished from any broad governmental system of medical service in effect at all times and for the benefit of other classes of society in addition to the indigent.

Referring to provisions of the Wagner Bill, pending in Congress and in which are incorporated the recommendations of the Committee on Economic Security, the House of Delegates said:

"While the desirability of adequate medical service for crippled children and for the preservation of child and maternal health is beyond question, the House of Delegates deplores and pro-

tests those sections * * * which place in the Children's Bureau of the Department of Labor the responsibility for the administration of funds for these purposes. The House of Delegates condemns as pernicious that section * * * which creates a social insurance board without specification of the character of its personnel to administer functions essentially medical in character and demanding technical knowledge not available to those without medical training."

NO "MODEL PLAN," REPORT SAYS

In support of its conclusion "there is no model plan which is a cure-all for the social ills any more than there is a panacea for the physical ills that affect mankind", the House of Delegates declared:

"There are now more than 150 plans for medical service undergoing study and trial in various communities in the United States. Your Bureau of Medical Economics has studied these plans and is now ready and willing to advise medical societies in the creation and operation of such plans. The plans developed by the Bureau of Medical Economics will serve the people of the community in the prevention of disease, the maintenance of health and the curative care in illness. They must at the same time meet apparent economic factors and protect the public welfare by safeguarding to the medical profession the functions of control of medical standards and the continued advancement of medical educational requirements. They must not destroy the initiative which is vital to the highest type of medical service."

The suggestion was emphasized that all such plans be carefully studied by the Bureau of Medical Economics "with special reference to the way in which they meet the needs of their communities, to the costs of operation, to the quality of service rendered, the effects of such service on the medical profession, the applicability to rural, village, urban and industrial population", and that the bureau develop skeleton plans adapted to the needs of populations of various types.

OHIO LEGISLATIVE POT BOILING BRISKLY

AFTER a brief delay in organizing, both branches of the Ohio General Assembly got down to business, especially on the function of introduction of proposals that were setting a record for variety at the time this issue of *The Journal* went to press.

Bills on practically every general governmental subject have been introduced, reflecting ideas and theories too prevalent in the present-day spirit for experimentation, innovation and regimentation.

As anticipated, the character of part of the proposed legislation has a decided socialistic tinge.

The situation in Ohio, as well as in other states, emphasizes the importance of activity and constant interest by conservative groups such as the medical profession, to preserve those fundamentals which are known to be sound and which have stood the test of experience. At the same time, the multiplication of social problems in the chaotic economic situation requires adjustments, some statutory amendments and changes in governmental procedure.

The major problem seems to be to preserve proven principles and policies and at the same time promote progress and improvement in the social and governmental structure through well-considered changes which are found necessary and desirable.

Following the adoption at the general election in 1933 of a constitutional amendment to permit legislation for reorganization, consolidation and changes in the structure of local and county government, the Governor's Commission on County Government, after many months of investigation and survey, has recommended to the Legislature a comprehensive program of legislation. The features of these recommendations of interest to the medical profession, applying particularly to health administration, welfare modifications in the coroner system and similar matters, were published somewhat in detail in last month's issue of *The Journal*, starting on page 138.

REORGANIZATION PROPOSALS

Based on the recommendations of the Governor's commission, bills have been introduced in the Legislature on the following general proposals:

Three alternate forms of county government depending on population and variable problems in the various classes of counties.

Optional transfer of powers by municipalities to the counties in which they are located.

Optional agreements between boards of county commissioners and political subdivisions.

Incorporation of counties adopting charters for combinations of functions and elimination of offices of some present public officials would be permissive.

Combination of offices of auditor and county

treasurer, and of county recorder and clerk of courts.

Optional establishment of county purchasing agent and county personnel agent.

Optional provision under charter set-up for various means of selecting a county manager where municipalities and territory outside municipalities in the same county mutually agree on such consolidation.

Creation of a medical examiner on the staff of the county prosecuting attorney to take the place of the present elective coroner system and to further provide that all such medical examiners, with functions enlarged from those of the present coroner, shall be physicians.

Provision for establishment of county welfare departments and consolidation of present scattered functions in the field of welfare and relief to the needy.

SOCIAL INSURANCE PROPOSALS

A number of far-reaching proposals have been introduced to establish governmental agencies to render services to individuals, including a proposal to establish a state insurance system to cover, broadly, unemployment, old age, sickness, maternity, and, as one newspaper observer described it, "all the ills to which the flesh is heir". It would authorize the Director of Industrial Relations to establish a system of unemployment insurance and "to provide for the immediate establishment of other forms of social insurance for the purpose of providing compensation for all workers and farmers who are unable to work because of sickness, old age, maternity, industrial injury or any other disability."

Of course, it is not at all likely that such a drastic and far-reaching proposal will be enacted and this is given as an extreme illustration. On the other hand, proposals are pending approaching various phases of this proposal and which are much more plausible in their apparent intent.

WORKMEN'S COMPENSATION

No less than a dozen bills have been introduced affecting workmen's compensation and its administration. Some of them would go so far as to broaden the term "injury" to include *any disability* of an employe and permit claims under the Workmen's Compensation Law for all types of injuries, illness or disabilities claimed by a potential beneficiary as having occurred in or arisen from employment.

Still other bills would enlarge the list of occupational diseases, and several propose to include "silicosis" in the list of compensable occupational diseases. Other bills would permit more ready appeals to the courts, thus prolonging adjudication and payment of benefits to employes and medical fees to attending physicians.

Revision of the present tax laws continues to be one of the most important and controversial issues before the Legislature.

Numerous measures have been introduced to amend the new Retail Sales Tax Law, to increase the list of exempted articles, to tap new sources of wealth by levying special taxes on various businesses, to tax earned incomes in addition to unearned incomes.

MISCELLANEOUS

Among the numerous bills in which the medical profession is directly interested are several dealing with changes in the state narcotic laws, county welfare set-ups, probate procedure, coroner system, sanitation, sewage, restriction on drugs, hospitals, changes in the poor laws, medical relief, state institutions, safety measures, automobile drivers' license and responsibility, reorganization of court procedure and appeal, sterilization, food inspection, dentistry, juvenile delinquency, insanity and the usual array of cult and anti-medical proposals.

Frequently, and at least once a week, the Policy Committee of the Ohio State Medical Association issues special bulletins to the legislative chairman in each of the county medical societies and academies of medicine, setting forth developments on pending legislation affecting medical practice and public health.

It is the duty of each committeeman to promptly disseminate information and suggestions to the other members of his local committee and to the members of his society, and to respond to requests for definite action and information on local situations and on contacts and conversations with the legislators from his community.

Members should request information from the legislative chairman of their county medical society or academy of medicine, and cooperate with him in the furtherance of the legislative program of medical organization in the promotion of public health and scientific medicine.

— OSMJ —

Medical Graduates Widely Distributed

Data compiled recently by Dr. J. H. J. Upham, dean of the College of Medicine, Ohio State University, show that out of the total of 1,806 graduates of that school, 7 per cent are located in towns of less than 1,000 population, 13 per cent in towns of from 1,000 to 5,000, and 8 per cent in communities from 5,000 to 10,000.

Graduates of the school are practicing in 421 different communities and 17 are located in foreign countries.

— OSMJ —

Wapakoneta—Dr. Frederick P. Berlin who has been serving his internship at Cleveland City Hospital, has been appointed assistant resident in surgery. Dr. Berlin is the son of Dr. C. C. Berlin in this city.

SMALL-WAGE EARNER SUPPLIED MEDICAL SERVICE ON TIME PAYMENT BASIS UNDER DETROIT PLAN; ITS OPERATION AND RESULTS SUMMARIZED

APPROXIMATELY one year ago the Wayne County Medical Society, Detroit, Michigan, inaugurated a medical service plan to supply employed persons of modest means with medical, dental, hospital and nursing services, when needed, at "fees commensurate with the patient's income and payable in installments within a year's time or less."

Much publicity has been given to and widespread interest aroused in this cooperative endeavor on the part of professional groups in Detroit to make available, under professional control and supervision and without the use of the insurance principle, complete medical care for small-wage earners who do not need or want charity, but credit, to assist them in meeting financial problems incidental to sickness.

Recent reports by officials of the Wayne County Medical Society who have been closely connected with the operation of the Detroit Medical Service Bureau, administrative agency under the plan, indicate the plan has demonstrated, as one commentator has stated, "that medical care can be supplied those who need it—not through insurance, not through government or political agencies, but through sane and unselfish work of the individual doctor of medicine coordinated by his county medical society".

What is the Detroit plan? How does it operate? What has it accomplished?

These and other pertinent questions have been and are being asked daily by members of the medical profession who have had little opportunity to inform themselves regarding the important features of the Detroit Medical Service Bureau.

The Journal has assembled a resume of the Detroit Medical Service Bureau plan from material which has been published from time to time in the *Detroit Medical News*, official publication of the Wayne County Medical Society, data obtained direct from officials of the Wayne County Medical Society, and Mr. K. B. Reed, manager of the Medical Service Bureau.

Publication of this material is in line with the policy of *The Journal* to keep the medical profession fully informed regarding trends and developments in the field of medical economics and of efforts being made to solve some of the vital problems confronting physicians and their patients.

The county medical societies and academies of medicine of Ohio might study the Detroit plan. It may offer a suggested solution to the problems of Ohio communities where conditions are similar to those in Detroit.

It has been pointed out that the basic idea of the plan is to keep medical practice under the control of the practitioners of medicine, a principle of universal application.

It may be found sufficiently flexible to permit some phases to be adopted to many localities, with changes in the detail of operation to comply with local conditions.

Some observers have pointed out that while it would not be feasible and practical for smaller communities to set up a "service plan" on a basis as elaborate as that of the Detroit plan, even small centers might put the idea into operation in a modest way; and that the "credit and installment" principle could be made use of by the individual physician in his business dealings with his patients of moderate means.

ORIGIN OF THE DETROIT PLAN

The medical service plan of the Wayne County Medical Society was formulated by Dr. Ralph H. Pino, Detroit. It was studied for a period of 18 months before it was finally approved by the Council of the society on February 16, 1934.

Shortly thereafter, sufficient funds were appropriated to create and maintain the Detroit Medical Service Bureau to put the plan into operation and handle the administrative details.

The bureau is owned and operated exclusively by the Wayne County Medical Society. It is located in the society's building at 4421 Woodward Avenue, Detroit. K. B. Reed is the full-time manager in charge.

The bureau is under the financial control of the Board of Trustees of the Wayne County Medical Society. Its operating policies are decided by an advisory board composed of three representatives of each of the following groups: Wayne County Medical Society, Detroit District Dental Society, Detroit Branch of the Michigan Nurses' Association, Detroit Retail Druggists' Association, and the hospitals of Detroit.

PURPOSE AND OBJECTIVES OF THE BUREAU

As stated previously, the Detroit Medical Service Bureau was organized to supply complete medical service to employed persons of modest incomes, when they need it and on terms they can afford to pay. It is a demonstration in cooperation

on the part of five professional groups directly concerned in meeting the medical and health needs of the public, especially that group of individuals who are not entitled to and do not want charity but who need credit arrangements to aid them in paying for their medical services. It furnishes the means for persons with no cash reserve, but who are able to make installment payments, to obtain necessary medical care from physicians and dentists of their own choice and not have to look to free dispensaries, tax supported hospitals, and clinics for medical services.

SOME IMPORTANT FEATURES ANALYZED

Under the medical service plan and administrative procedure of the bureau, the headquarters of the Wayne County Medical Society is a central coordinating center for cases requiring assistance in obtaining and paying for complete medical service, including services of a physician, hospitalization, dentistry, nursing and pharmaceutical service.

The members of the Wayne County Medical Society are the active staff caring for patients.

All forms of medical care, consultation, *X*-ray and laboratory procedures are performed in the office or laboratory of the physician, or at the hospital where the physician takes the patient.

All cases, where the benefits of the coordinating plan are desired, are registered at the bureau. The patient is permitted and encouraged to select his own physician—his family physician if he has one—and he is given an identification card to be presented to the physician selected.

The plan preserves the recognized patient-physician relationship. The patient always has a free choice of physician and the physician has free choice of hospital, specialists, laboratories, etc., exactly as in private practice.

It does not include workmen's compensation cases. Cases of unemployed persons who are on the relief rolls are not handled by the Medical Service Bureau but by the Medical-Dental Bureau of the F.E.R.A. which also is located in the headquarters office of the Wayne County Medical Society.

No collections are made by the physician from patients using the bureau plan. The physician sends his bill, computed at the usual fees for patients of the moderate income class, to the bureau, accompanied by certain details of the charges. The bureau, which has already made arrangements for collection of the bill with the patient on definite terms, handles all the details of collection and pays the physician as the money is paid to the bureau by the patient.

The bureau makes a service charge of 10 per cent of all monies collected. No assessment is paid by the patient. The service charge is subtracted from the amounts due those who render the professional service. If several physicians, and or, a hospital cooperate in the care of a case, the bills for fees are combined into one bill and terms are arranged according to the patient's ability to pay. Payments received by the bureau from the patient are distributed among the physicians, hospitals, etc. Occasionally, with the full consent of the physician, the bureau modifies the fee charged in accord with the patient's financial circumstances.

The bureau accepts cases from physicians who are not members of the Wayne County Medical Society in order to preserve the traditional physician-patient relationship. However, since a portion of the dues paid by the members of the society are used to help finance the work of the bureau, physicians not members are assessed a slightly higher service charge than the flat 10 per cent assessed members of the society submitting bills.

EXAMPLE OF HOW BUREAU OPERATES

When a patient applies to the bureau for assistance in obtaining medical service, he is given an interview and referred to the physician, dentist, etc., of his choice.

The employer also is interviewed to determine credit rating and the character of the person applying for service. Under the Detroit plan, it is anticipated that eventually a modern social and financial fact-finding bureau will be established to facilitate this work.

The physician selected diagnoses the illness and furnishes treatment. When necessary he obtains the services of a hospital, specialist, etc., through the bureau.

All who supply service send bills to the Medical Service Bureau where they are debited to the patient's account. Out of his wages the patient pays to the bureau an amount agreed upon at the time he applied for service. These sums are based solely upon the patient's ability to pay. His total indebtedness is so adjusted that the period of payment will not exceed one year.

Collections from patients are distributed to the cooperating professional units as follows: The first $25.00 (approximately 50 per cent of the average hospital bill) is paid to the hospital if hospitalization is necessary; subsequent collections are distributed periodically, half to the hospital and half pro-rated among the others who have cooperated in the service.

Following is an illustration:

John Brown applies to the bureau for assistance in obtaining surgical service and estimates that he can pay $25.00 down and $10.00 a month. Service is rendered by Dr. Jones whose fee is $40.00; Dr. Thompson, whose fee is $10.00 and Providence Hospital which charges $60.00.

John Brown's account would be posted as follows:

Charges	*Dr.*	*Cr.*	*Balance*	*Distribution of Collections*			
				Dr. Jones	*Dr. Thompson*	*Hospital*	*Service Charge*
Dr. Jones	$40.00						
Dr. Thompson	10.00						
Hospital	60.00						
				$36.00	$9.00	$54.00	$11.00
Total charges			$110.00				
Payments:							
Down Payment		$25.00	$85.00	.....	.....	$22.50	$2.50
2nd Month	10.00		75.00	3.60	.90	4.50	1.00
3rd Month	10.00		65.00	3.60	.90	4.50	1.00
4th Month	10.00		55.00	3.60	.90	4.50	1.00
5th Month	10.00		45.00	3.60	.90	4.50	1.00
6th Month	10.00		35.00	3.60	.90	4.50	1.00
7th Month	10.00		25.00	3.60	.90	4.50	1.00
8th Month	10.00		15.00	3.60	.90	4.50	1.00
9th Month	10.00		5.00	7.20	1.80	pd. out	1.00
10th Month	5.00		.....	3.60	.90	pd. out	.50

SERVICES RENDERED BY BUREAU

Up to December 26, 1934, the Detroit Medical Service Bureau had served 1489 patients and had not refused service to any deserving applicant. In every case the service was rendered immediately without red tape.

Very little publicity has been disseminated direct to workmen. However, the bureau's functions have been explained to the personnel officers of 35 of Detroit's leading industrial concerns, employing approximately 250,000 men.

Among Detroit firms which are cooperating with the bureau and which have employes receiving the benefits of the bureau are: Borden's Farm Products Co., Detroit Edison Company, Parke Davis & Co., Burroughs Adding Machine Co., Graham Paige Motors Corp., Packard Motor Company, Bower Roller Bearing Company, Atlantic & Pacific Tea Co., Hupp Motor Company, Hudson Motor Car Company, Gregory Mayer & Thom Co., Chevrolet Motor Company, Detroit Post Office, Dodge Brothers, Chrysler Motors, De Soto Motors, Plymouth Motors, Motor Products Company, Ford Motor Company, J. L. Hudson Company, Detroit Street Railways, Fisher Body Corp., General Motors Research Corp., Clayton & Lambert Co., C. M. Hall Lamp Co., Detroit Rock Salt Co., Briggs Manufacturing Co., U. S. Rubber Co., Kelvinator Corporation, Crowley Milner & Co.

The patients referred by industry, private practitioners and social agencies have in the main required services of physicians and surgeons. About 65 per cent have required hospitalization.

Up to November 1, 1934, bills had been received by the bureau from cooperating professional units as follows:

Physicians	$ 64,549.98
Dentists	1,056.50
Hospitals	41,615.75
Old accounts	2,263.78
Pharmacal	11.87
Others (Nurses, ambulances, etc.)	173.40
Total	$109,671.28

As of December 24, 1934, patients had paid to the bureau in small installments a total of $33,047.52.

REACTION TO THE PLAN

There are approximately 7,000 professional units (physicians, dentists, nurses, druggists, and hospitals) in Wayne County. Practically all of them are cooperating in the plan.

According to Manager Reed's report on the work of the bureau during its first year:

"To date we have encountered no difficulty in obtaining professional services. This is not surprising as it is in line with the best traditions of medical practice. A number of doctors refer all problem cases to the bureau. The bureau assists the doctor by working out a fair plan with each patient. These doctors realize that a pittance from each of a large number of cases amounts to a surprising total—and most doctors can use such extra income. Doctors prefer the small payments to serving the same patient in a free ward. They also realize that the patient neither wants or needs charity—his prime need is credit, which the bureau grants."

PATIENTS' ATTITUDE ON SERVICE

Patients are on the whole grateful to the Detroit medical profession for having adopted this method of assisting them to meet the financial problems of sickness, according to Mr. Reed.

"We have many letters expressing appreciation and an even larger number of verbal expressions," he reports.

"The low-wage group fear that their lack of finances will prevent them from receiving complete service; that, while their own doctor may be willing to give service, the service of a specialist or a hospital is beyond their means. The average patient is delighted when we explain that our service covers all health requirements and that the terms will be adjusted to meet their present income; that the patient selects his own physician; and that we are *not* giving charity. The results of such friendly, fair treatment are apparent in

our collections. During the last half of 1934, many of Detroit's industries were practically closed, and many workmen were laid off. In spite of this fact, our records indicate that 50 per cent kept up the installments and that the vast majority of the delinquents came to us voluntarily and explained the reason for their delinquency."

EMPLOYERS ARE COOPERATIVE

The employers of Detroit who are familiar with the work of the Medical Service Bureau have commended the plan and are cooperating, as Mr. Reed has pointed out:

"Apparently the employer is very happy to be able to let someone else look after the details of securing medical service for their men. We have the active cooperation of every industrialist to whom our plan has been explained. 'Selling' the industrialist has proved to be a pleasure."

The employers contacted have been informed of the profits which will accrue to them through increased efficiency of his employes as well as these advantages: certainty that the employe will be well cared for; relief from a portion of the necessity for employe loans; one centralized bureau with which to cooperate; and, no dues, fees, payments of any kind before actual service has been rendered.

All employers contacted have stated they are glad to cooperate in making collections with one central bureau but that it is impossible to do so with several thousand physicians, dentists, nurses, etc. Their reason is obvious. One central bureau, such as the Medical Service Bureau, makes it possible for them to make only one deduction in compiling payrolls to cover the medical care of their men. The amount of bookkeeping necessary in this case is small, in comparison to the enormous amount of paper work that would be required to make payroll deductions to cover the charges of several thousand physicians, dentists, etc., submitting individual bills for services rendered.

In some cases employers guarantee bills contracted by their employes with the bureau. Some pay bills in advance for their employes; others arrange for a wage assignment. All employers contacted have assisted in various ways to get patients to pay their installments on time.

WELFARE AGENCIES ASSISTING

The bureau has obtained the cooperation of many of Detroit's welfare agencies which have to do with furnishing medical care. Officials of these agencies are referring all patients able to pay something to the bureau. This has resulted in a savings in public funds and has kept many patients in the hands of private practitioners instead of clinics and dispensaries, thus lessening the load of these agencies and keeping physician-patient relationships intact in many instances. It has been found that in most cases referred to the bureau from welfare agencies, a plan for installment payments for medical care is feasible. Out of the first 12 cases referred from the Probate Court, the bureau was able to return 10 to private practitioners. What they needed was credit, not charity.

It is reported that the Detroit Medical Service Bureau has surpassed during its first year even the expectations of its sponsors. Plans for expanding its operations and its administrative staff are contemplated. A campaign of sustained and dignified publicity through the employer to the employe has been carried on. Personal contacts with employers have been made. By increasing promotional activity, the bureau hopes during the ensuing year to obtain the cooperation of many more of the 2400 industrial units or employers in Wayne County; return many more persons able to meet medical expenses, if extended credit on reasonable terms, to physicians in private practice; increase the income of those rendering professional service, and discourage any movement to establish a government, socialized system to supply medical service to the low-wage earning classes.

— OSMJ —

NEW BOOKS RECEIVED

Report on Seventh International Congress of Military Medicine and Pharmacy and Meetings of the Permanent Committee, by Capt. William S. Bainbridge, Mc-F., USNR, member of permanent committee and delegate from the United States; report of meetings held at Madrid, Spain, May 29-June 3, 1933.

Aids to Psychiatry, by W. S. Dawson, M.D., F.R.C.P., London, professor of psychiatry, University of Sydney; third edition; emphasizing matters of special importance to the medical student and the general practitioner; William Wood & Company, Baltimore, publishers; price, $1.50.

Annual Report of the Surgeon General, U. S. Public Health Service, for Fiscal Year 1934; the 63rd annual report of the service submitted to the Congress of the United States.

Aids to Embryology, by Richard H. Hunter, M.D., lecturer in anatomy, Queen's University, Belfast; second edition; William Wood & Company, Baltimore, publishers; price, $1.25.

A Synopsis of Medicine, by Henry Letheby Tidy, M.D., physician to St. Thomas Hospital, London, England; sixth edition, revised and enlarged; a remarkable compilation of summaries to numerous diseases and conditions for students, hurried practitioners and examiners; not a textbook but synopses for "those who have to revise rapidly their knowledge of medicine in general or of some disease in particular"; The William & Wilkins Co., Mt. Royal and Guilford Avenues, Baltimore; price, $6.00.

MEDICAL PROBLEMS IN CONNECTION WITH POOR RELIEF SUBMITTED TO NEW STATE RELIEF DIRECTOR

SUCCEEDING former Adjutant General Frank D. Henderson, William A. Walls of Kent, former Kent superintendent of schools, has been appointed by Governor Davey and installed as Executive Director of the State Relief Commission.

Several changes have been made on the Commission. Mr. T. S. Graham of Akron, vice president of the Goodrich Rubber Company; Frank G. Kleinhenz of Cleveland, and John Cunningham of Gambier have been appointed to the Commission.

The new appointees succeed former Highway Director O. W. Merrell, Brigadier General Frank D. Henderson and Fred A. Miller of Columbus. At the same time Governor Davey announced the reappointment of Dr. Josephine Pierce of Lima, an osteopath and former president of the Ohio Federation of Women's Clubs, as the representative of organized club women on the Commission. Clarence Burk, former State Finance Director, was also reappointed.

Representatives of the State Medical Association have already submitted recommendations to the new relief director for the organization of local medical advisory committees to represent county medical societies and academies of medicine in contact with local relief directors in the solution of problems and in the supervision of medical care to the needy, as a method to eliminate much misunderstanding which has occurred in some communities, to minimize difficulties and to secure better cooperation. It will be remembered that Regulations 7 of the FERA contemplate such official advisory committees, but thus far the former State Relief Commission has declined to adopt this provision.

In view of the fact that budgets and appropriations for other relief to the various counties are not made on a per capita basis but in accordance with actual needs and funds available, efforts are being made to induce the State Relief Commission to abandon the impractical limitation of $1.00 per family per month on relief and the related regulation of pro-rating at the end of the month when the total for medical services exceeds that amount.

As pointed out repeatedly over a period of months in the *Ohio State Medical Journal*, the $1.00 per family per month allotment for medical care and the pro-rating provision means that in some communities, especially where there is an abnormal amount of sickness, physicians are receiving a reduced percentage of each dollar of service rendered considerably below the meagre and inadequate fee schedule itself, which was promulgated by the State Relief Commission. If county medical societies have and will continue to insist to their local relief directors that such a system is inequitable and inadequate, and if such local officials and county medical societies will cooperate in this demand with the State Association, it is possible that the State Relief Commission can be convinced of the desirability of eliminating the present restriction on the amount allotted for and expended for medical care.

Figures at the State Relief Commission show that in the month of December $6,496,079 of federal-state funds were administered for the relief of the needy in Ohio, of which $182,555, or 3 per cent of the total, was expended for medical care.

Legislation has been introduced in the Ohio General Assembly to continue the State Relief Commission for two more years, with the idea of adjusting the situation and its administration to whatever the federal government may work out along the lines of employment on part or full-time on public works to decrease the number of those on direct relief rolls, and possibly to return gradually to the state and the local communities the responsibility of caring for those who were not otherwise cared for through employment and who still remain on the list of needy.

Through legislation and regulations, the State Relief Commission also expects to require those counties and political subdivisions which have not already obligated themselves through appropriate bond issues for the purpose, to issue such bonds for temporary and emergency relief, in order that other counties may receive their proportionate share of federal-state funds in addition to funds raised locally.

While the sales tax was expected to provide considerable funds for poor relief, the interest on bonds already issued, the diversion of such taxes to obligations already incurred, and the major proportion going to schools primarily and local political subdivisions secondarily, it is estimated by officials of the State Relief Commission that at the present rate there will probably be a deficit of approximately $1,000,000 a month from the amount estimated to be necessary for relief for several months to come.

One means of relieving this situation, it is believed, would be a federal plan of employment on public work or an increase in the appropriation from federal funds for direct relief in Ohio.

Study Outline No. 9

STUDY OF ANEMIA

Arranged by M. A. Blankenhorn, M.D., and F. R. Miller, M.D., Lakeside Hospital, Cleveland, Ohio

1. Classification[1]
   - A. Etiology
     1. Deficiency
        - a. Anti-anemic substance in liver
        - b. Iron[10, 11]
        - c. Diet—(iron and vitamins)[2, 3]
        - d. Glands of internal secretion
     2. Blood loss—acute and chronic
     3. Due to systemic disease[18, 19]
     4. Pathological condition of bone marrow[22]
     5. Action of toxic agent or infective agent as bone marrow and peripheral blood[8, 9]
   - B. As to blood findings
     1. Hyperchromic—macrocytic
     2. Hypochromic—microcytic[4, 5, 6, 7]
     3. Normal color index
2. Physiology of blood forming and destroying organs, and alterations in anemia.
   - A. Bone Marrow
   - B. Liver and spleen
   - C. Stomach
3. Pathology of anemias
   - A. Of bone marrow in various types of anemia
   - B. Of spleen in various types of anemia
   - C. Of liver in various types of anemia
   - D. Of stomach in various types of anemia
4. Laboratory work involved in diagnosis
   - A. Of first importance
     1. RBC
     2. Hgb. (RBC and Hb give color index)
     3. Gastric analysis with histamine
     4. Smear
   - B. Of second importance
     1. WBC
     2. Reticulocyte counts (in diag. and progress of disease)
     3. Volume index
     4. Cell size[12]
     5. Saturation index
     6. Icteric index
     7. Stool examination
5. Signs and symptoms of anemia
   - A. General
     1. Pallor
     2. Weakness
     3. Loss of weight
     4. Edema
     5. Heart action—murmurs, etc.
     6. Appearance of mucus membranes
     7. Dyspnea
   - B. Special signs and symptoms in conditions with anemia related to the lack of the whole or part of the anti-anemic factor of liver[20, 21]
     1. Sore mouth and tongue
     2. Gastric distress
     3. Tingling and numbness of hands and feet
     4. Neurological signs and symptoms
     5. Enlargement of spleen and liver (one or both)
     6. Icterus
   - C. Special signs and symptoms in hemolytic anemia or those due to toxic or infective action in bone marrow or peripheral blood
     1. Hemorrhage and petechiae
     2. Enlarged liver and spleen
     3. Icterus
   - D. Signs and symptoms of systemic disease which may be cause of anemia
6. Treatment of anemia[15]
   - A. Depends on etiology
   - B. Treatment of anemia due to lack of anti-anemic substance in liver (whole or part)
     1. Oral administration of liver extract or other preparations[16, 17]
        - a. Dosage—initial and maintenance
     2. Intravenous and intramuscular administration of liver extract
        - a. Indication
        - b. Dosage—initial and maintenance
   - C. Treatment of anemias due to lack of iron (including those due to hemorrhage)[13, 14]
     1. Oral administration and dosage
     2. Parenteral administration
   - D. Special therapy for some hemolytic anemias
     1. Transfusion
     2. Splenectomy
   - E. Treatment of anemia must include treatment of the systemic disease when it is the underlying cause of anemia

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News Notes From County Societies and Academies

First District

ACADEMY OF MEDICINE OF CINCINNATI

(H. J. Lavender, M.D., Secretary)

Meetings of the Academy held during February were as follows:

February 4—General Session. Program: "Danger Signals", by Dr. Walter Freeman, Professor of Neurology, George Washington University, Washington, D. C.

February 11—General Session. Program: "Study in Experimental Peripheral Gangrene and the Effect of the Ovarian Hormone", by Dr. Edward McGrath; discussion by Dr. Richard S. Austin and Dr. Louis G. Herrmann. "Jaundice: Clinical Consideration", by Dr. Leon Schiff; discussion by Dr. Henry W. Bettmann and Dr. M. M. Zinninger.

February 18—General Session. Program: "Past and Present Concepts of Eczema and its Treatment", by Dr. Karl G. Zwick. "Physico-Chemical Observations", by Dr. Fred O'Flaherty. "Eczema in Children", by Dr. A. Graeme Mitchell. Report of the Physicians' Business Bureau, by Mr. Ray Swink.

February 25 — General Session. Program: "The Treatment of Hemorrhoids—A Critique", by Dr. Charles Ross Deeds; discussion by Dr. Charles Howard. "The Treatment of Pelvic Pain in Women by the Resection of the Superior Hypogastric Plexus", by Dr. E. A. Kindel; discussion by Dr. Eslie Asbury and Dr. Joseph Heiman.

Clinton County Medical Society held its regular monthly meeting on Tuesday, February 5, at the General Denver Hotel, Wilmington, with fifteen members present. A feature of the program was a round-table discussion on the care of the indigent sick, which followed a paper presented by Dr. C. A. Tribbett, of Westboro.—News Clipping

Second District

Darke County Medical Society met in regular session on Friday evening, February 15, in the Christian Church, Greenville. Following a dinner at 6:30 P. M., Dr. R. W. Kissane of Columbus spoke on "Pertinent Facts in Cardiology".—W. D. Bishop, M.D., Secretary.

Greene County Medical Society, at its meeting in Xenia on February 7, enjoyed a talk by Dr. Robert Conard, of Wilmington, "On Being Inquisitive", which was a reminder to the general practitioner of the usefulness of simple laboratory methods in everyday diagnosis. Dr. Donald Kyle, of Cedarville, on recommendation of the Board of Censors, was voted a member of the society.—Reyburn McClellan, M.D., Secretary.

Miami County Medical Society met at the Nurses Home, Memorial Hospital, Piqua, on Friday afternoon, February 1. Dr. Homer Cassell, of Dayton, presented a paper on "The Medical Management of Diabetes", and Dr. Russell Gardner, of Troy, opened the discussion. Dinner was served at 6:00 to those in attendance.—Bulletin.

Montgomery County Medical Society held its regular monthly meeting Friday evening, February 15, with a complimentary dinner at the St. Elizabeth's Hospital. Dr. Louis G. Herrmann, Assistant Professor of Surgery, Cincinnati General Hospital, spoke on "Diagnosis and Treatment of More Common Arterial Diseases of the Extremities".

On February 1, the society held a dinner at the Van Cleve Hotel, Dayton. "Psychoneurotic Reactions" was the subject of an address by Dr.

Charles P. Emerson, Dean of the Indiana University School of Medicine, Indianapolis.—Bulletin.

Third District

Hancock County Medical Society met at the Elks Home in Findlay on Thursday evening, February 7, with members of adjoining county medical societies as guests. Dr. Edward J. McGrath, of the University of Cincinnati, spoke on recent developments in the treatment of vascular diseases of the extremities.—News Clipping.

Hardin County Medical Society held its regular meeting on Thursday evening, January 17, in Kenton. Dr. Robert L. Barnes, Columbus, spoke on "The Treatment of Arthritis".—News Clipping.

Logan County Medical Society met for its regular February session at the Logan Hotel, Bellefontaine, on February 1, 1935, with a dinner at 6:30 P. M., and then before 90 per cent of the paid-up members of the county society, Dr. C. A. Coleman, of Dayton, gave a very instructive and informative talk on "New Developments in the Treatment of Genito-Urinary Diseases". His address was thoroughly enjoyed and appreciated by all those present.

The regular meeting for January was held on Friday the 18th at Hotel Ingalls, Bellefontaine. Following dinner at 6:30 P. M., Dr. J. P. Harbert, Bellefontaine, gave a very interesting paper on "Head Injuries", followed by a round-table discussion, which was instructive.—M. L. Pratt, M.D., Secretary.

Marion County—The Marion Academy of Medicine had as guest speakers at its meeting at the City Hospital, Marion, on Tuesday evening, February 5, Drs. Perry and Roy McCullagh, of Cleveland. Both talks, which were illustrated, were on the general subject of "Endocrinology". Physicians and nurses from surrounding counties were guests of the society.—News Clipipng.

Fourth District

TOLEDO ACADEMY OF MEDICINE

(F. C. Clifford, M.D., Secretary)

The following meetings were held by the Academy during February:

February 1—General Session. Program: "A Demonstration of a New Appliance for the Treatment of Hip Fractures", by Dr. B. W. Culver, Coldwater, Michigan. "Tuberculosis of the Genito-Urinary Tract", with lantern slide demonstration, by Dr. C. E. Burford, Professor of Urology, St. Louis University School of Medicine.

February 8—Section of Pathology, Experimental Medicine and Bacteriology. Program: "Symposium on Tumors of the Urinary Bladder", by Dr. J. A. H. Magoun and Dr. Leo P. Dolan; discussion by Dr. John T. Murphy, Dr. A. Rees Klopfenstein and Dr. E. W. Huffer.

February 15—Medical Section. Program: "The Role of a Medical Officer in the U. S. Navy", by Lt. Comdr. Joseph E. Malcomson, (MC) USN., Ninth Naval District, Detroit, Michigan.

February 22—Surgical Section. Program. "The Management of the Surgery of the Large Bowel", by Dr. Wm. A. Neill; discussion by Dr. W. W. Green and Dr. J. W. Davis.—Bulletin.

Defiance County Medical Society held its regular meeting at the Defiance Hospital, Defiance, on Tuesday evening, January 22. The program for the evening was a symposium on still births, with papers by Dr. George DeMuth, Dr. E. C. Wurst, Dr. P. B. Newcomb, Dr. G. E. Winn and Dr. D. W. Travis.—News Clipping.

Ottawa County Medical Society, at its regular session on Thursday evening, January 17, elected the following officers for 1935: President, Dr. L. L. Belt, Marblehead; vice president, Dr. E. D. Schuiteman, Genoa; secretary-treasurer, Dr. C. R. Wood, Port Clinton. Dr. J. W. Burrows, Lakeside, and Dr. Charles J. Wood, Genoa, who recently located in the county were admitted to membership.—News Clipping.

Sandusky County Medical Society met in Fremont on Thursday evening, January 24. Dr. H. K. Shumaker, of Bellevue, gave an interesting report of a case of eclampsia, and Dr. Carl Wolfe, the secretary, reported on recent rulings of the Tax Commission, relieving physicians from the necessity of collecting sales tax, and listing them as consumers rather than vendors.—News Clippings.

Wood County Medical Society held its January meeting in the Woman's Club, Bowling Green, on Thursday evening, January 17, with a good attendance. E. C. Powell, of the State College Faculty, gave an enjoyable talk on "If I Were a Physician".—News Clipping.

Fifth District

CLEVELAND ACADEMY OF MEDICINE

(J. A. Garvin, M.D., Secretary)

Meetings of the Academy held during February were as follows:

February 1—Clinical and Pathological Section. Program: "Duodenal Ulcer. Problems in Treatment. Case Presentation". By Dr. C. E. Steyer. "Foreign Body in Intestine with Perforations", Dr. F. T. Gallagher. "Fatal Post-operative Pulmonary Atelectasis", Dr. H. Sneiderman. "Pleuritis Mediastinalis Superior in Infants", Dr. Otto L. Goehle. "*X*-ray Visualization of the Gastric Mucous Membrane", Dr. David Steel. "Simple Fracture of Vault of Cranium with Unusual Complications", Dr. G. P. O'Malley, and discussion by Dr. C. L. McDonald. "Congenital Bladder Neck Obstruction", Dr. W. J. Manning. "Chronic Ulcerative Colitis", E. J. Stefanic.

February 8—Experimental Medicine Section

and Cleveland Section of the Society for Experimental Biology and Medicine. Program. "Normergic and Allergic Inflammation", Dr. B. S. Kline and Dr. A. M. Young. "Further Studies on the Production of Collateral Blood Supply to the Heart", Dr. C. S. Beck. "The Pathological Anatomy of Coronary Thrombosis with Reference to the Development of Collateral Circulation", Dr. A. R. Moritz, and Dr. C. S. Beck. "Experimental Hypertension; Further Study", Dr. H. Goldblatt, and P. M. Glenn, B.S. "The Interstitial Cells of the Testicle in Individuals with Malignant Tumors", E. E. Collins. "Experimental Observations on the Frei Test in Lymphogranuloma Inguinale", Dr. M. Sullivan and Dr. E. E. Ecker. "Some Clinical Observations on the Frei Test", Dr. W. H. Connor, and Dr. E. A. Levin. "The Aschheim-Zondek Test with Mature Mice", Dr. A. G. SarLouis.

February 13—Practice of Medicine Section. Program: "Two Fatal Cases of Rheumatic Fever with Pulmonary Complications. Autopsy Findings", Dr. E. C. Oberson. "Notes on the Etiology of Rheumatic Fever", Dr. Howard T. Karsner. "The Sedimentation Test—Description of the Test and its use in the Study of Rheumatic Fever", Dr. W. R. Hallaran.

February 18—Regular Meeting. Program. "Medical Economics", by Dr. James S. McLester, Birmingham, President-Elect of the American Medical Association.

February 20—Industrial Medicine and Orthopedic Section. Program: "Compression Fracture of the Third Dorsal Vetebra" (Presentation of Case), Dr. J. R. Ripton. "Injuries of the Ear", Dr. J. T. Collins. "Ambulatory Treatment in Fractures of the Cervical Vetebrae" (Demonstration of an original apparatus), Dr. R. J. Schraff. "Recent Developments in the Management of Fractures", Dr. G. I. Bauman. "Some Observations on Fractures of the Lower Jaw", Thomas F. Healy, D.D.S. (by invitation.)

February 28—Ophthalmological and Oto-Laryngological Section. Program: Clinic presentation by the Department of Ophthalmology and Oto-Laryngology of Lakeside Hospital.—Bulletin.

Erie County Medical Society held its January meeting on Thursday evening, January 31, at the Boulevard restaurant, Sandusky. Following the business session, Dr. Ross Knoble addressed the society. A social hour was enjoyed following the program.—News Clipping.

Lake County Medical Society heard an address on "The Classification of Nephritis: Diagnosis and Treatment", by Dr. C. D. Christie, of Cleveland, at its regular meeting held on Tuesday, January 29, at the Lake County Memorial Hospital, Painesville.—News Clipping.

Medina County Medical Society met Thursday afternoon, January 24, at the Municipal Hospital, Wadsworth, for its regular meeting. Dr. R. E. Pinkerton, of Akron, spoke on the subject of "Common Neurologic Conditions". Dinner at 5:30 was served at the hospital by the Auxiliary.—News Clipping.

Sixth District

Ashland County Medical Society held its regular meeting at the Ashland Country Club, Ashland, Thursday evening, February 8, when a fine chicken dinner was served to the physicians and their wives. After the dinner, bridge and dominoes were the diversion, aside from much conversation. Prizes were awarded to Mrs. M. J. Thomas, Jeromeville, and Dr. M. D. Shilling, of Ashland, for high scores of the evening.—M. J. Thomas, M.D., Secretary.

Mahoning County Medical Society met at the Youngstown Club, Tuesday evening, February 12. Dr. George Draper, Professor of Clinical Medicine, Columbia University, spoke on the subject of "The Emotional Factor in the Problems of Internal Medicine".—Bulletin.

Summit County Medical Society held its regular meeting on Tuesday evening, February 5, at the Mayflower Hotel, Akron. Program for the evening included an address on "Sensitivity to Common Foods", by Dr. Karl D. Figley, of Toledo.—Bulletin.

Stark County Medical Society, at its annual meeting held Tuesday evening, January 17, at the Woman's Club, Canton, elected the following officers for 1935: President, Dr. M. E. Scott, Canton; vice president, Dr. J. E. Aten, Canton; secretary-treasurer, Dr. H. W. Beck, Canton; delegates to the state meeting, Dr. J. P. DeWitt of Canton, and Dr. A. R. Basinger, of North Canton; alternates, Dr. W. G. Lyle of Minerva, and Dr. J. D. Holston, of Massillon, member of the board of censors, Dr. B. C. Barnard, of Alliance. —News Clipping.

Portage County Medical Society met at the residence of Dr. J. M. Painter, in Kent, on Thursday evening, February 7, for its regular monthly meeting. Dr. L. L. Bottsford, Akron, guest speaker, discussed "Some Phases of Obstetrics". —Bulletin.

Wayne County Medical Society met in Hygeia Hall, Wooster College campus, Friday evening, January 25, with a large attendance. The following interesting and varied program was presented by physicians from Orrville: "Treatment of Varicose Ulcers", (with presentation of case), by Dr. O. C. McDowell; "Report of a Case of Gastric Ulcer", by Dr. O. P. Ulrich; "Report of a Pneumonia Case Treated with Gluco-Calcium", by Dr. O. G. Grady; "Reminiscenses", by Dr. A. A. Brooks; "Report of a Case of Placenta Previa", by Dr. Robert Hecker; "What Would You Have Done?" by Dr. G. H. Irvin, Sr. A general discus-

sion followed presentation of program, and was very interesting as well as instructive.—R. C. Paul, M.D., Secretary.

Seventh District

Belmont County Medical Society held its regular monthly meeting at Kilkenny Inn, Bellaire, on Thursday afternoon, February 7. A paper on "Acute Appendicitis" was presented by Dr. F. S. Wright, of Bellaire. A six o'clock dinner followed the program.—Bulletin.

Eighth District

Athens County Medical Society met in the Legion Home, Nelsonville, Monday, February 4, for its regular monthly meeting, with twenty members and three physicians from Hocking County as guests at the luncheon. Dr. C. S. McDougall delivered an address in memory of the late Dr. J. L. Henry, of Athens. Dr. John R. Sprague spoke on the subject of "Diagnosis in Abdominal Surgery".—News Clipping.

Fairfield County Medical Society held a luncheon meeting at the Martens Hotel, Lancaster, on Tuesday, February 12. The guest speaker, Dr. C. W. Pavey, of University Hospital, Columbus, spoke on "Advances in Obstetrics in 1934".—News Clipping.

Guernsey County Medical Society, meeting Thursday, January 17, for a luncheon meeting at the Berwick Hotel, Cambridge, heard an excellent paper on "Arthritis", by Dr. Gordon Lawyer. Dr. A. G. Ringer led the discussion which followed. A short business session was held before presentation of the program.

An Thursday, February 7, Dr. C. R. Johnston delivered an interesting address on "Renal Calculus or Kidney Stones". A general discussion followed the presentation of his paper.

A joint meeting of the society with dentists of the city was held on Thursday, January 31. Roy G. Pfaadt, D.D.S., pointed out the dentists' views on state health insurance, and Dr. Fred Lane spoke from the physicians' standpoint. Twenty physicians and fifteen dentists were present at the meeting, which was preceded by a dinner at the Berwick Hotel, Cambridge.

On Thursday evening, February 14, the Sisters of St. Francis of Wells Hospital entertained members of the Guernsey County Medical Society with a dinner at the Berwick Hotel.—News Clipping.

Licking County Medical Society, at its meeting held on Friday, January 25, at the Newark City Hospital, elected the following officers for 1935: President, Dr. Geraldine H. Crocker, Granville; secretary-treasurer, Dr. G. A. Gressle, Newark. "Treatment of Heart Disease" was the subject of an address by Dr. R. W. Kissane of Columbus, A dinner was served at 6 o'clock.—News Clipping.

On Friday, February 22, Dr. George Curtis, Ohio State University College of Medicine, Columbus, addressed the society on "Collapse Therapy in Pulmonary Tuberculosis".—News Clipping.

Muskingum County—The February meeting of the Muskingum County Academy of Medicine was held in the University Club rooms, on Wednesday evening, February 6. Dr. J. O. Rankin, of the Wheeling Clinic, spoke on "Osteomyelitis", and Dr. W. K. Kalbfleisch, also of the Wheeling Clinic, discussed "Bone Tumors". Luncheon was served after the meeting.—Bulletin.

The January meeting of the Academy was devoted to transaction of routine business, and was in charge of the president, Dr. W. D. Coffman.—News Clipping.

Ninth District

Lawrence County Medical Society held its regular meeting at the Deaconess Hospital, Ironton, on Thursday, February 7. No regular program was presented, but the time was devoted to discussion of local conditions. Care of indigents, not now provided for under the relief administration to be brought to attention of City Council discussed by Dr. Ralph Massie, who also proposed appointment to staff of Deaconess Hospital, to care for indigents and accidents, appointment to be made by the president. A program of medical education, under the supervision of Dr. V. V. Smith, will soon be put under way.—W. Wilson Lynd, M.D., Secretary.

Scioto County—The regular meeting of the Hempstead Academy of Medicine was held Monday evening, February 11, at the Nurses Home, Portsmouth. Program consisted of motion pictures on "Modern Methods of Anesthesia". Buffet lunch was served.—Bulletin.

Tenth District

COLUMBUS ACADEMY OF MEDICINE

(Drew L. Davies, M.D., Secretary)

January 20—Memorial service in the Broad Street Presbyterian Church, conducted by Reverend J. Harry Cotton, honoring the following members of the Academy who passed away the latter part of 1933, and during 1934: Drs. Alfred C. Smith, Alfred Robinson, Kossuth Tinker, Zed V. Luke, George Tryon Harding, Jr., Samuel Blinz Hays, Robert J. Williams, Ernest Scott, I. J. Mizer, Clarence J. Burns, Ross Hopkins, E. A. Calloway, Clarence I. Britt, Harold York Masefield, Norman Eckelberry, George C. Schaeffer, Willard B. Carpenter, Clarence Maris, Albert B. Davenport, William F. Whitten, J. E. Campbell Taylor.

January 21—Regular meeting. Program: "Co-

lumbus Bureau of Medical Economics". Discussion by Dr. S. J. Goodman, Dr. J. M. Dunn, Dr. E. F. McCampbell, and Dr. Russell G. Means. "Female Sex Hormones", (lantern slide demonstration), Dr. E. J. Stedem.

January 28—Program: "Tumors of the Colon", Dr. John F. Erdman, New York City, Professor of Surgery, Columbia University.

February 4—General Practitioners' Section. Program: "Angina Pectoris", Dr. Howard Whitehead. "Coronary Thrombosis", Dr. C. M. Larrick; discussion by Dr. Thomas T. Frost and Dr. E. F. McCampbell.

February 11—General meeting. "Group Hospitalization" (Cleveland plan), Mr. John A. McNamara, Cleveland, director.

February 18—General Meeting. Symposium on Tuberculosis: "Bed Rest in the Treatment of Tuberculosis", Dr. Robert W. Kropp; "The Little Things We Forget to Tell the Tuberculosis Patient", Dr. C. H. Benson; "Fluroscopy in the Diagnosis of Pulmonary Tuberculosis", Dr. P. T. Knies; "Surgery in Tuberculosis", Dr. Louis Mark; "Collapse Therapy at Franklin County Tuberculosis Hospital", Dr. Myron D. Miller.

February 25—General Meeting. Program: "Convulsions in Infancy" (lantern slides), Dr. John Edwin Brown, Jr.; Discussion by Dr. E. G. Horton and Dr. J. P. Farson. "Orthodontic Defects as Related to General Medicine" (Lantern slides), Frederick R. Aldrich, D.D.S.—Bulletin.

Crawford County Medical Society held its regular meeting on Monday evening, February 4 at the Bucyrus City Hospital. Guest speakers were Dr. Howard L. Stitt and Dr. C. E. Wooding, of Cincinnati, who presented the interesting subject of the "Treatment of Non-Tubercular Pulmonary Lesions". Their papers were accompanied by motion picture demonstration.—C. A. Lingenfelter, M.D., Correspondent.

Madison County Medical Society held a dinner meeting on Thursday, January 31, at Mt. Sterling. Matters of legislation, relief, and health work were discussed. New members recently admitted to membership in the society include Dr. J. A. Knapp and Dr. W. M. McShane, of London. —News Clipping.

Ross County Academy of Medicine met on Thursday evening, February 7, for a dinner meeting at the Dunn Glen Manor, Chillicothe. The guest speaker was Dr. William Davis, of Toledo. —News Clipping.

— OSMJ —

Springfield—Announcement has been made of the marriage of Miss Pauline Greshel, formerly of Chicago, and Dr. J. A. Link, in Vienna, Austria, on December 3. The couple will remain in Europe for several months where Dr. Link is attending clinics.



J. Eugene Baker, M.D., Marion; Miami Medical College, Cincinnati, 1883; aged 77; former member of the Ohio State Medical Association; died January 25 of heart disease. Dr. Baker began practice in 1883 at Martel. Nine years later he took post graduate work in Edinburgh, Scotland. Twenty-eight of his 52 years in practice, were spent at Caledonia. He is survived by his widow, two daughters, one sister and one brother.

Justin Guy Ballou, M.D., Oak Harbor; University of Illinois, College of Medicine, Chicago; 1905; aged 53; member of the Ohio State Medical Association and Fellow of the American Medical Association; died January 29 of pneumonia. Dr. Ballou had practiced at Oak Harbor since his discharge from military service in the World War. He was elected mayor of Oak Harbor in 1933, and held that office at the time of his death. Surviving him are his widow and one son.

Harold J. Beard, M.D., Youngstown; Kentucky School of Medicine, Louisville, Kentucky, 1901; aged 54; member of the Ohio State Medical Association and Fellow of the American Medical Association; died January 30, of heart disease. Dr. Beard practiced in Hardinsburg, Kentucky, until he became associated in practice with Dr. R. D. Gibson, in Youngstown, 14 years ago. He was a past president of the Youngstown Club, and a member of the American Academy of Ophthalmology and Oto-laryngology. He is survived by his father, a brother, and two sisters.

Wilbur M. L. Beatty, M.D., Centerburg; Starling Medical College, Columbus, 1890; aged 74; died January 30 in the Mt. Vernon hospital-sanitarium, following a two-years' illness. He is survived by his widow, one son, two daughters and two sisters.

William Chase Bennett, M.D., Toledo; Rush Medical College, Chicago, 1893; aged 68; died January 31. Before his retirement, Dr. Bennett practiced in Toledo, and was formerly a member of the Milwaukee Health Department and a state health officer in Wisconsin, and served in the Medical Corps during the World War. Surviving him are his widow, a daughter and a son, Dr. Donald, of Louisville, Kentucky, and a brother Dr. Louis J., Kenosha, Wisconsin.

Homer M. Calvin, M.D., Salineville; Columbus Medical College, 1891; aged 66; former member of the Ohio State Medical Association; died Feb-

ruary 3. He started to practice in Salineville shortly after graduation. In 1929 he removed to Alliance, but after two years returned to Salineville. He is survived by one daughter, one son, two sisters and two brothers.

James L. Cannon, M.D., Toledo; Medical College of Ohio, Cincinnati, 1901; aged 63; died January 14. His widow and one daughter survive him.

Frank E. Deeds, M.D., Sandusky; Albany Medical College, Albany, New York, 1914; aged 45; former member of the Ohio State Medical Association; died January 16 at Winston-Salem, North Carolina, where he had gone in an effort to regain his health. Dr. Deeds practiced in Akron before locating in Sandusky several years ago. He is survived by his widow, a daughter, a son, and his mother.

George Almon Kelley, M.D., Canton; Western Reserve University School of Medicine, 1880; aged 77; member of the Ohio State Medical Association and Fellow of the American Medical Association; died January 31 following several months' illness of acute arthritis. Dr. Kelley had been in active practice in Canton more than 40 years, and for 27 years he had been a member of the medical staff of Aultman hospital. He had practiced at Wooster, and at Burns, Kansas, for 11 years before locating in Canton. His widow, one son and one daughter survive him.

Karl Elmer Ochs, M.D., Cleveland; Western Reserve University School of Medicine, 1904; aged 55; member of the Ohio State Medical Association and Fellow of the American Medical Association, died February 6. Dr. Ochs had practiced in Cleveland for several years. Surviving him are his widow, a daughter and a son.

J. Vinson Richardson, M.D., Fort Recovery; Medical College of Ohio, Cincinnati, 1872; aged 84; former member of the Ohio State Medical Association; died January 29 from pneumonia. Dr. Richardson was the son of the late Dr. and Mrs. John Richardson, and had practiced in Fort Recovery and Mercer County for 40 years before his retirement several years ago. Surviving him are his daughter and one brother, Dr. D. H. Richardson, of Celina.

Fred L. Singrey, M.D., Mt. Vernon; Starling Medical College, Columbus, 1898; aged 59; member of the Ohio State Medical Association and the American Medical Association, died January 28 of an attack of angina pectoris. Dr. Singrey located in Amity following his graduation, and practiced there for eight years before moving to Mt. Vernon. He is survived by his widow, two daughters and a sister.

Austin T. Woods, M.D., Loyal Oaks; Western Reserve University, School of Medicine, Cleveland, 1879; aged 79; died January 15. Dr. Woods had been a resident of Summit County for 56 years and had practiced at Loyal Oak since his graduation. One daughter survives him.

KNOWN IN OHIO

Lafayette Skaggs, M.D., Russell, Kentucky; Kentucky School of Medicine, Louisville, 1894; aged 74. Dr. Skaggs had practiced in Russell for the past 16 years, and had served three terms as coroner of Greenup County. He is survived by his widow, one daughter, and four sons.

Noble Van Zant, M.D., Momence, Illinois; University of Illinois, College of Medicine, Chicago, 1906; aged 53; Dr. Van Zant was born in Hillsboro, and following graduation, practiced in Clermont County, before locating in Momence. His widow and four children survive him.

George S. Weger, M.D., Redlands, California; Baltimore Medical College, Baltimore, Maryland, 1898; aged 60; died January 16 of heart disease. Dr. Weger formerly practiced in Delphos. One brother survives him.

DeWitt Clinton Wilson, M.D., Los Angeles, California; Bellevue Hospital Medical College, New York, 1870; aged 88; died February 1. Dr Wilson, a native of Lawrence County, practiced in Ironton for several years before locating in Los Angeles, California. Dr. Wilson paid an annual visit to his home town of Ironton. One daughter survives him.

— OSMJ —

Claim Canned Meat Not To Blame For Sickness at Toledo

Several laboratory food specialists, and a number of trained meat inspectors, including a specialist on canned meats, have returned a verdict of "wholesome" in favor of the relief meat distributed in Toledo, Ohio, and vicinity, where suspicion was recently aroused because of a number of cases of illness among children.

When a representative of the Toledo Department of Health questioned the wholesomeness of the canned beef being distributed in the city because of a noticeable number of digestive disturbances among children in two of the city schools, the Department of Agriculture at Washington immediately ordered a meat inspector at Detroit and a food and drug inspector from Cincinnati to make a first-hand study of the situation and to send in samples of the meat. The reports show no evidence of spoiled meat.

— OSMJ —

Fostoria—Dr. J. L. Murphy has been attending clinics at the Mayo Hospital, Rochester, Minn.

— OSMJ —

Zanesville—Dr. M. A. Loebell attended a meeting of the Association for the Study of Cancer at Washington, D. C.

WORKMEN'S COMPENSATION

Digest of Recent Court Decisions and Excerpts of Interest to Physicians Pertaining to Industrial Commission Cases and Administrative Procedure.

EVERY physician whose services are sought by a disabled workman should promptly secure from the patient accurate data on the cause and origin of his disability and all circumstances incidental thereto so that he can determine with some degree of accuracy whether the workman is entitled to compensation and medical care under the Workmen's Compensation Law or whether the patient will be responsible personally for the payment of medical bills.

During recent months, a number of claims filed with the State Industrial Commission have been rejected by the Commission, together with bills of physicians for services to such applicants, on the ground that the injuries sustained were *not accidental in their origin and cause.*

This action was in line with the newly-adopted policy of the Commission in adhering strictly to the intent and meaning of the Workmen's Compensation Law by requiring all applicants to furnish substantial proof of some *accident or unusual and unforeseen circumstance* in connection with the injury or that the disability is the result of one of the occupational diseases enumerated in the statutes.

The Commission's policy in tightening up on the admission of applications for compensation and medical services is based on a number of decisions by the Ohio Supreme Court, the most important of which is that rendered in *Industrial Commission of Ohio v. Franken* (126 O.S., 299).

In the Franken case the Supreme Court held:

1. The Constitution and statutes of this state make a clear distinction between injury and disease. The only diseases which are compensable are certain occupational diseases enumerated by the statute.

2. The term "injury" as used in the Workmen's Compensation Law of Ohio comprehends only such injuries as are accidental in their origin and cause.

The case originated in the Common Pleas Court of Franklin County. It was an appeal from the action of the State Industrial Commission denying to Mary Franken, widow of Henry Franken, an employe of the Ohio State Stove Company, participation in the Workmen's Compensation Fund by reason of his death which it was claimed resulted from an injury sustained by him while at work.

The trial resulted in a verdict for the plaintiff and this judgment was sustained by the appellate court. The record was ordered certified to the Ohio Supreme Court.

The single question presented was whether the facts disclosed by the record warranted an award under Section 1465-37, et seq., General Code, part of the workmen's compensation statutes.

The Supreme Court's decision, written by Judge Matthias, said in part:

"The record discloses that Franken had been in the employ of the Ohio State Stove Company for nineteen years as a 'pressman'; his particular task being to handle dies, which weighed from 25 to 400 pounds, an apparatus being provided and used to handle those which were too heavy to be lifted otherwise. No 'accident' occurred, as that term is ordinarily understood and applied.

"Some time during the day above mentioned Franken made some complaint about not feeling well and quit work and went home. He died 25 days later, his trouble being diagnosed as heart failure. At the time he quit work he complained of indigestion. The record discloses that upon arriving home he had pains through his chest, and the doctor later stated that he was suffering from an acute dilation of the heart. There is no evidence whatever of any extraordinary or unusual happening in and about Franken's work preceding his illness.

"There is some evidence that on the day in question he had handled a die weighing 300 pounds, but it does not appear that handling a die of that weight with the apparatus provided was any more strenuous than lifting by hand a die weighing 35 or 40 pounds. The physician testified that in his opinion the heart condition described was caused by 'some severe muscular strain'.

"The right of recovery in any case such as this cannot be determined upon the theory that the work in which the employe was engaged was heavy, or of a strenuous character, and by reason of long continuance resulted in physical impairment. It cannot be claimed that there may be a recovery from the workmen's compensation fund by reason of a disease or physical ailment not the direct result of an injury. The Constitution, and the statute enacted thereunder, have made a clear distinction between injury and disease, and the only diseases which have been made compensable are certain occupational diseases enumerated by the statute. The fact that work being done by the employe is light or heavy work has no place in the consideration of the right to recover, for what is heavy work for one man may for another be so light as to involve no hazard at all. Impairment of physical condition accruing from constant and continued labor, no matter how heavy or arduous it may be, is not covered by the Workmen's Compensation Law. Such impairment does not come within the meaning of the term 'injury', and that is true whether the term 'injury' as used in the Workmen's Compensation Law, contemplates accidental injury. However, unless the entire theory of the Workmen's Compensation Law which has obtained in this state for many years is to be dis-

regarded and the many decisions of this court involving the question are to be reversed, it must be held that the term 'injury' as used in the Ohio Workmen's Compensation Law comprehends only such injuries as are accidental in their origin and cause.

"This has been the holding of this court since the case of *Industrial Commission v. Brown*, 92 Ohio St., 309, 110 N.E., 744, L.R.A., 1916B, 1277, and the doctrine therein stated has been reiterated in *Industrial Commission v. Roth*, 98 Ohio St., 120 N.E., 172, 6 A.L.R. 1463, *Industrial Commission v. Cross*, 104 Ohio St., 561, 136 N.E., 283, *Renkel v. Industrial Commission*, 109 Ohio St., 152, 141 N.E., 834, and *Industrial Commission v. Russell*, 111 Ohio St., 692, 146 N.E., 305.

"If the scope of cases compensable is to be extended, it should be done by unambiguous legislative enactment. Judgment reversed."

To reiterate, a physician handling industrial accident cases should know something of the legal status of the case so that he can have an understanding with the patient regarding payment for his services in event the workman's claim should be turned down by the Industrial Commission.

* * *

For the first time in five years payments into the Ohio Workmen's Compensation Fund exceeded disbursements during 1934.

Figures announced by officials of the State Industrial Commission show a total premium collection from employers during the past calendar year slightly in excess of $16,000,000, while two years ago the amount in round numbers was $10,000,000.

One of the reasons for the increase, officials of the Industrial Commission believe, was the improvement in business and consequent increase in employment in 1934.

Another important factor has been improvement in enforcement, compelling more employers who were failing to comply with the Workmen's Compensation Law to contribute to the fund. Following the findings in Cuyahoga County alone where payroll audits showed a deficiency of almost $700,000 and following several indictments for payroll fraud, many non-complying employers hastened to pay the current and delinquent premiums, which added materially to the income during the past year.

After the new enforcement division was created at the Commission several months ago and when non-compliance is discovered, this fact is called to the attention of the employer, and if he fails to make proper payment, the findings in the case are turned over to the Attorney General's department for collection.

Few suits have been filed, but many employers have been found willing to settle for the amount assessed by the Commission plus interest.

* * *

Following are several recent decisions of the State Industrial Commission with respect to unusual claims and those with peculiar medical or legal angles:

An employe of a Delaware bread company died of sunstroke on June 30, 1934, while on his route as a bread salesman and his widow filed an application for a death award. The evidence in the case was to the effect that he sustained the attack while on his regular route, although the maximum temperature on the day of his death was only 85 degrees. The claims reviewer, while noting that there appears to be little question that the circumstances of death were as alleged, was of the opinion that decedent's employment did not subject him to any greater risk than was common to all and cited a number of recent Supreme Court decisions which held that death due to sunstroke was not an injury within the meaning of the Workmen's Compensation Law. *The Commission denied the award.*

* * *

A woman employee of a Cincinnati firm reported for duty on the eleventh floor of the company building and after putting her wraps in the locker started to walk down the stairs to the ninth floor to deliver a letter to her sister. She tripped and fell, suffering a brain concussion which disabled her for seven weeks. The employer paid her regular salary during the period, hence her claim was for the allowance of $300 medical fee. The claims reviewer was of the opinion that claimant was on a personal errand at the time of injury and that the injury was not compensable. *The Commission so held and disallowed the claim.*

* * *

A young woman employed in a Cleveland restaurant fell on a stairway while at work and struck her chin on a step. She was compensated for disability but recently applied for compensation for facial disfigurement, the injury having affected the nerves in her face and causing a disfigurement which she alleged prevented her from securing employment. *The claim was approved by the medical department and the Industrial Commission granted her an award of $600 for facial disfigurement.*

* * *

An employe of a Columbus oil company sustained injuries on March 26, 1934, when he was struck in the breast by a shackle bar while lubricating an automobile. He entered claim for compensation but before action was taken he died. An investigation by the medical department resulted in a report setting out the improbability of the injury having produced the lung condition which caused death, it being held that such a condition could not develop from an injury in such a short space of time and that the symptoms the second day following the alleged injury were of far advanced lung pathology. The application of the widow for a death award *was denied* by the Commission, which held that death of decedent was *not* due to the injury alleged.

NEWS NOTES of OHIO

Cincinnati—A permanent fellowship in surgery will be established in the College of Medicine, University of Cincinnati, through the generosity of Mrs. William Cooper Proctor.

Lima—Dr. P. I. Tussing spoke on "Preventive Medicine" at a recent meeting of the Lima Parent Teacher's Association.

Washington C. H.—Dr. Jack Persinger, former resident physician at Children's Hospital, Columbus, has opened offices here.

Conneaut—Dr. Perry Longaker, formerly of Dayton, has located in this city, and will be associated in practice with Dr. B. C. Eades.

Middletown—Dr. C. T. Atkinson has returned from several weeks spent at Miami, Florida.

College Corner—Dr. W. H. Hawley was honored with a surprise dinner January 17, commemorating fifty years in the active practice of medicine. Dr. W. L. Porter of College Corner presided as toastmaster, and talks were made by Dr. J. C. Oliver, Dr. Oliver P. Holt and Dr. Robert Sattler of Cincinnati, and Dr. Mark Millikin of Hamilton.

Columbus—Dr. Eugene F. McCampbell, has been named president of the Columbus Bureau of Medical Economics, official agency of the Columbus Academy of Medicine in business matters. Other officers are Dr. J. Mitchell Dunn, vice president; Dr. Russell G. Means, secretary-treasurer. Trustees are Drs. J. J. Coons, V. A. Dodd, E. G. Horton, S. J. Goodman, R. W. Kissane, R. E. Krigbaum and John M. Thomas.

Cincinnati—Dr. Richard Austin of the College of Medicine of the University of Cincinnati, spoke on "Opportunities in the Field of Medicine" as the third of a series of seven lectures on occupational trends, sponsored by the Y. M. C. A. Vocational Guidance Committee.

Springfield—Dr. James Burgman was a patient in the American Hospital, Paris, in February.

Wellston—Mrs. Carrie Davis Eisman of Gallipolis and Dr. Oscar McLaughlin of Rocky Hill, were married January 20.

Wellston—The Wellston Rotary Club at its January meeting, heard four interesting talks on the current trends in medicine, given by Dr. H. W. Gillen, Dr. J. L. Frazer, Dr. Mel Smith and Dr. E. T. Dando.

Columbus—Dr. John A. Riebel has been a patient in Good Samaritan Hospital, Ashland, following an auto accident near Ashland, February 5, in which he was painfully injured.

Cleveland—Dr. T. Wingate Todd and Dr. Holly B. Broadbent, of the faculty of the School of Medicine of Western Reserve University, were in New York, January 28, to address the Eastern Edward Angle Association on "The Physical Constitution of a Child".

Akron—Dr. J. H. Seiler, secretary of the Union (Sixth District) Medical Association since its organization in 1870, tendered his resignation at the recent quarterly meeting, and is spending the winter at Southern Pines, North Carolina. In appreciation of his long service, he was elected secretary emeritus of the Association.

Oxford—Dr. Wade MacMillan, for 17 years medical director at Miami University, has announced his retirement, effective next Fall.

Wooster—Dr. Joseph H. Todd, "father" of the Wayne County Medical Society, and probably one of the oldest physicians in the country, recently celebrated his 98th birthday. Dr. Todd began practice in Wooster in 1865, and still sees a few select patients.

Washington C. H.—Four Fayette County physicians were patients in Columbus hospitals recently—Dr. James F. Wilson, health commissioner, and secretary of the Fayette County Medical Society, for an operation; Dr. Lucy Pine, for treatment of a badly injured hip; Dr. C. A. Teeters, for treatment of a fractured hip, and Dr. Frank E. Wilson, for treatment of an infected arm.

Medina—Dr. R. G. Johnston, formerly of Geneva, New York, has purchased the practice of the late Dr. R. G. Strong.

New Philadelphia—Dr. Clare Smith, formerly of Marion, has located here.

Ashtabula—Dr. W. F. Gessler has moved to Ft. Wayne, Indiana, where he has opened offices to specialize in eye, ear, nose and throat work.

Eaton—Dr. James I. Nisbet has been re-appointed health commissioner of Preble County.

Kent—Dr. J. M. Painter, graduate of the Western Reserve University, School of Medicine, has opened offices here.

Conneaut—Dr. and Mrs. J. F. Docherty have returned from a European trip during which Dr. Docherty visited clinics at London, Paris and Berlin.

Columbus—Dr. J. F. Baldwin has recovered from injuries received when struck by an automobile.

Akron—The Akron Doctors' Symphony cele-

brated its eighth anniversary by giving a concert at the Peoples' Hospital under the direction of Dr. A. S. McCormick.

Alliance—Dr. G. O. Rowland has been reappointed health commissioner of Alliance.

Cincinnati—A gift of $12,500 from Mrs. David May to the University of Cincinnati, College of Medicine, will be used to further the work of the department of internal medicine, the University trustees have announced.

Oberlin—Dr. R. W. Bradshaw, head of the student health service, Oberlin College, was reelected president of the American Student Health Association at the recent annual meeting of that organization in New York City.

McConnellsville—Dr. C. E. Northup attended the post-graduate courses given at the University of Buffalo School of Medicine.

Upper Sandusky—Dr. C. B. Schoolfield, formerly of Dover and Carbon, West Va., and son of Dr. E. R. Schoolfield, Bucyrus, has opened offices here.

Alliance—Dr. F. P. Bennett has returned from a seven weeks' trip through South America.

Greenville—Dr. W. C. Gutermuth, Versailles, has been appointed a trustee of the Greenville Hospital, succeeding Dr. William Matchett, resigned.

Founder's Day Clinics Held at College of Medicine, O. S. U.

Hundreds of alumni of the College of Medicine, Ohio State University, were expected to attend the 101st Annual Founder's Day Clinics, scheduled for Friday, March 1, and Saturday, March 2.

Two physicians of national reputation were scheduled to address the alumni. Dr. Edward D. Churchill, John Homan's professor of surgery, Harvard Medical College, was to give the Alpha Omega Alpha address on "Lobectomy and Total Pneumonectomy", on Friday evening, March 1. On Saturday morning, March 2, the alumni were to be addressed by Dr. Russell H. Oppenheimer, dean, Emory Medical College, Atlanta, Georgia, on "The Doctor's Place in Modern Economic and Social Life".

Medical and surgical clinics and demonstrations were to be given on both days at University, St. Francis and Children's hospitals. A post-collegiate review course for all alumni was scheduled for Friday afternoon, March 1, at University Hospital, the subject being "The Normal and Pathological Metabolic Reactions of the Glands of Internal Secretion". Another review course was scheduled for Saturday morning, March 2, on cardiological subjects. Class luncheons have been planned for Saturday noon and fraternity banquets that evening.

The committee in charge of the 1935 reunion

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Reduced Railroad Fares—One and one-third the one-way fare for the round trip. A "certificate of identification" must be secured from the Executive Secretary of the College to entitle physicians and dependent members of their families to these reduced fares.

Philadelphia Headquarters—General Headquarters, Philadelphia Municipal Auditorium, 34th Street below Spruce Street. Hotel Headquarters, The Benjamin Franklin Hotel, 9th and Chestnut Streets.

Invitation is extended to all qualified physicians. Non-members of the College will pay a nominal registration fee.

Address inquiries and requests for programs to the Executive Secretary

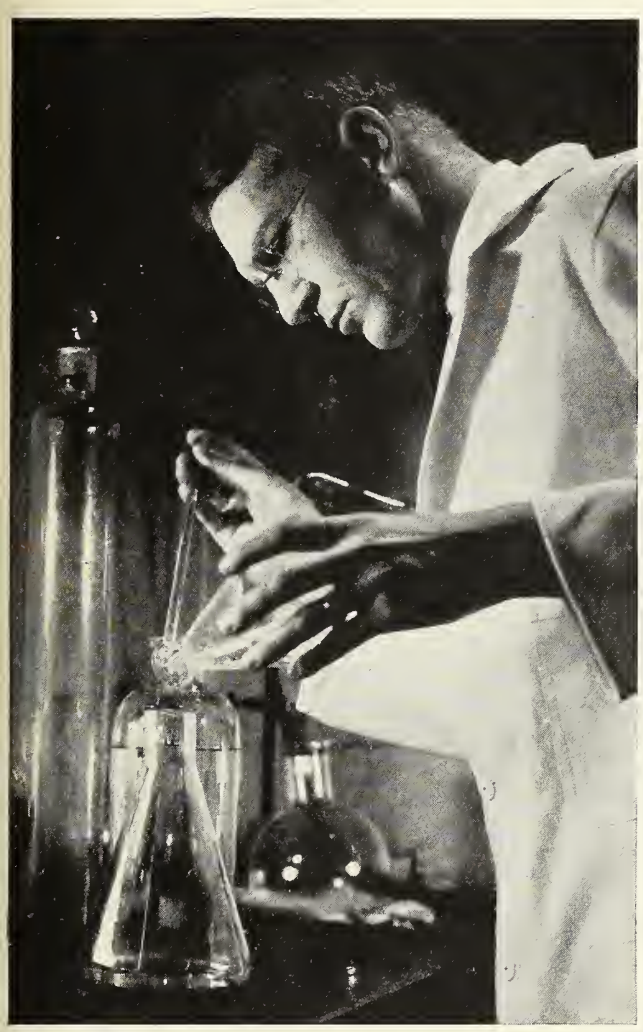
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consisted of Dr. Russell G. Means, chairman, Dr. Jonathan Forman, Dr. I. B. Harris, Dr. S. A. Hatfield, Dr. E. G. Horton and Dr. H. M. Platter. The program committee was composed of Dr. Harry Reinhart, chairman, Dr. L. L. Bigelow, Dr. R. R. Durant, Dr. G. I. Nelson, Dr. C. C. Smith, Dr. L. H. VanBuskirk and Dr. B. K. Wiseman. Ex-officio members of the committees were: President George W. Rightmire, Dr. J. H. J. Upham, dean of the College of Medicine, and John B. Fullen, alumni secretary.

In this connection, it has been announced that two more volumes on the history of the College of Medicine are being planned, to supplement the One Hundred Year Book which has been published. Dr. Jonathan Forman has been appointed historian to collect supplemental records and other material of historical value.

PUBLIC HEALTH NOTES

In addition to the many hours of hard work required to familiarize himself with his new duties, the State Director of Health, Dr. Walter H. Hartung, has been called upon to attend a number of health meetings throughout the state. Among two of the recent meetings he attended were the Southwestern Section of the Ohio Federation of Public Health Officials and the Northwestern Section of that organization, which consists of local health commissioners and other public health workers.

At the meeting of the former group, a resolution was adopted favoring legislation which would provide funds amounting to 40 cents per capita in the state to be applied to public health administration and health education.

—Lorain County District Department of Health will continue the tuberculosis survey started in the schools of 1934. The Mantoux test will be used to find pupils who sometime during their life have been infected with tuberculosis.

—Approximately 500 persons in Richland County were under quarantine in January in an outbreak of measles, according to a report to the City Board of Health by Dr. M. C. Hanson, city-county health commissioner.

—Dr. Ed. Blair, Lebanon, has been re-appointed health commissioner of Warren County for a term of two years. Miss Kathryn Gibbons was appointed county health nurse for a nine-month year.

—Dr. E. M. Wright, and Dr. Harold Lear, of Coshocton, were both re-appointed to five-year terms on the city health board.

—A diagnostic chest clinic was held at Wadsworth Municipal Hospital on February 6, through cooperation of the State Department of Health,

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FAECES-VACCINES
EFFUSIONS
STOMACH CONTENTS
PREGNANCY TEST
DARK FIELD—SPIROCHETA
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Prompt and Full Report

the Medina County and Wadsworth city health departments, under direction of Dr. T. W. Mahoney county health commissioner. Examinations were made by Dr. T. L. Bliss of Springfield Lake Sanatorium, East Akron, and Dr. A. H. Smith, Lorain County Tuberculosis Sanatorium.

—Annual report of Mrs. Emma R. Davis, county tuberculosis nurse, shows an increase in tuberculosis in Lake County. The report lists 92 cases in 1934 as compared to 79 in 1933, and 72 suspected cases in 1934 compared to 67 in 1933. At the five clinics held during 1934, a total of 203 patients were examined, with discovery of 30 positive and 12 suspected cases.

—Dr. C. V. Clifford, city health commissioner of Girard has announced plans for a school health program which will include vaccination and the Schick test, to be carried out by local physicians.

—Dr. L. H. Gaston, for two years associated with the State Department of Health, has been appointed full-time physician for the city health department of Mansfield.

HOSPITAL NOTES

—Staff officers of Good Samaritan Hospital, Dayton, elected at a dinner meeting held January 14, are: President, Dr. R. L. Johnston; vice president, Dr. C. H. Tate; secretary, Dr. A. J. Price. The executive board members are Dr. Johnston, Dr. Price, Dr. B. W. Beatty, Dr. N. C. Hochwalt, and Sister Mary Daniels, superintendent of the hospital.

—Dr. Charles J. McDevitt is the new president of the medical and surgical staff of Good Samaritan Hospital, Cincinnati. Others elected at the annual staff meeting, January 15, are: Dr. George Topmoeller, vice president; Dr. Lloyd Felter, secretary, and Dr. William Freyhoff, member of the executive board. Interns appointed for 1935 are: Edward J. Devins, George W. Yauger, F. William Vockell, John J. Kearney, Eugene L. Huwe, and James F. Mills, from Cincinnati Medical College; John A. Lamps, James William Joseph, and John J. Shea, from St. Louis University Medical School; J. Harry Dornheggen, Loyola Medical School, and J. Kenneth Jackson, Indiana University Medical School.

Dr. C. L. McDonald has been elected chief of staff at St. John's Hospital, Cleveland. Dr. C. A. O'Connell, is vice chief, and Dr. R. J. Schaff, visiting surgeon, is secretary-treasurer. Other members of the executive board whose terms extend to January 1, 1936, are: Dr. R. K. Updegraff, director of medicine; Dr. George P. O'Mal-

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Department of pediatrics—Supervisor, Dr. O. L. Goehle; visiting pediatricians, Drs. L. S. Schumacher, G. H. Mraz, J. P. Gavan; assistant visiting pediatricians, Dr. Daniel L. Gallagher.

Department of urology—Drs. J. B. Morgan, William J. Manning; assistant visiting urologist, Dr. J. A. Sommers.

Visiting orthopedist—Dr. G. I. Bauman; visiting orthopedist, Dr. R. P. Bell.

Visiting dermatologist, Dr. L. J. Carson; visiting proctologist, Dr. C. C. Perry; visiting pathologist, Dr. H. Sneiderman; roentgenologist, Dr. David Steel; visiting dentist, Dr. T. Healy.

—Dr. Andre Crotti, Columbus, has been elected chairman of the combined medical and surgical staffs at Grant Hospital, Columbus, succeeding Dr. John Dudley Dunham, general staff chairman in 1934. Dr. Drew L. Davies was named secretary. Newly elected chairmen of divisions of the staff include Dr. Orville Baldwin, medical; Dr. F. W. Thomas, eye, ear, nose and throat; and Dr. S. J. Goodman, obstetrics.

—Construction has been started on the William W. Roche Memorial Hospital, Toledo, which will house county tubercular patients. The hospital, when completed, will be equipped to care for 275 patients, and will cost $625,000.

—William E. Harrington, Alliance, has been appointed finance director of City Hospital, Alliance.

—Miss Isabella F. Hopkins, Cincinnati, founder of Cincinnati Children's Hospital, died February 3, on her 87th birthday.

—A plan for the building of an addition to the Deaconess Hospital, Ironton, and converting the institution into a city-county supported hospital has been launched by the Lawrence County Medical Society and various civic organizations.

—Dr. G. W. Hamilton, Akron, was elected chief of the medical and surgical staff of the Citizens' Hospital, Barberton, to succeed Dr. George R. Taylor, of Barberton. Dr. E. A. Irish, Barberton, was elected secretary, succeeding Dr. Hamilton. Dr. Frank M. Warner, West Barberton, was elected to the senior staff.

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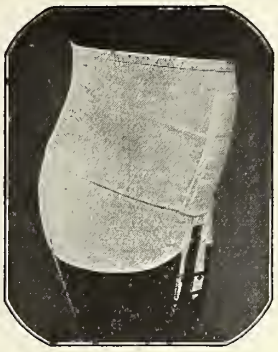
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—Mortgage indebtedness of Woman's Hospital, Cleveland, was paid off recently upon receipt of $14,621, given to the hospital by C. W. Stage, Jr., in memory of his mother who died in the Cleveland Clinic disaster.

—The new house staff at Mt. Sinai Hospital, Cleveland, for 1934-35 has been announced by Dr. H. L. Rockwood, director, as follows: Residents, Dr. Elmer Gooel, Western Reserve, surgery; Dr. Joseph Gross, University of Louisville, surgery; Dr. Alvin Tramer, Western Reserve, orthopedics and specialties; Dr. Robert Blondis, University of Indiana, medicine; Dr. Herschel Pevaroff, Western Reserve, obstetrics; Dr. Ruben K. Strauss, Western Reserve, pathology; interns, Dr. Isadore Cash, University of Wisconsin; Dr. Edward D. Schwartz, Western Reserve; Dr. Milton P. Wallenstein, Western Reserve; Dr. Phillip Wasserman, University of Rochester; Dr. Harold G. Pritzker, University of Toronto; Dr. Sidney N. Goldstein, University of Cincinnati; Dr. J. L. Friedman, Ohio State University; Dr. Morton L. Goldhamer, Western Reserve; Dr. Julian B. Galvin, Western Reserve; Dr. Elmer D. Engelman, Ohio State University, and Dr. Bernard H. Koosed, D.D.S., Western Reserve.

—Dr. J. M. Firmin has been re-elected chief of staff of the Findlay Home and Hospital. Dr. J. C. Tritch, for many years chief of staff, was elected to the newly-created office of chief consultant.

—New wing of the Martins Ferry Hospital was dedicated recently, giving the hospital a capacity of 100 beds.

—A public reception was held recently at the Mansfield General Hospital when a new $70,000 annex, providing 18 additional rooms, an assembly room and various utility rooms, was dedicated.

—A medical library, surgical instruments and physical therapy equipment has been given to the Lake County Memorial Hospital by the estate of the late Dr. R. H. Spence.

Fifteen hundred attended the official dedication of the remodeled Swan Hospital, Cambridge.

—St. Luke's Hospital, Cleveland, has put into effect inclusive flat rates for all services rendered by the hospital.

—Mrs. Charles F. Whisler, Hillsboro, has donated $10,000 to the Hillsboro Hospital for the installation of an elevator.

—Dr. R. L. Rutledge has been elected president of the staff of Alliance City Hosiptal. Other officers are: Vice president, Dr. H. L. Weaver; secretary, Dr. K. E. Reighard; treasurer, Dr. R. R. Mosley.

—The staff of St. Joseph's Hospital, Lorain, has elected Dr. S. C. Ward, as president for the ensuing year. Other officers are: Vice president, Dr. Robert Stack; secretary-treasurer, Dr. Ben Carlson.

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Ohio State Medical Journal

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PUBLIC HEALTH - SOCIAL WELFARE MEDICAL ECONOMICS and ORGANIZATION PROBLEMS

Council, With Regret, Accepts Resignation of Don K. Martin

To *The Journal* has fallen the unpleasant assignment of officially informing the membership of the Ohio State Medical Association of the resignation of Don K. Martin as executive secretary and general counsel of the State Association and editor-manager of the *Ohio State Medical Journal.*

As shown in the minutes of the meeting of the Council, held on Sunday, March 10, in Columbus and published elsewhere in this issue of *The Journal,* the Council with reluctance and an official expression of deep regret, accepted Mr. Martin's resignation, effective March 15.

Medical organization has suffered a great loss through the decision of Don K. Martin to accept the splendid opportunities which lie before him in connection with his new duties as manager of the Ohio Manufacturers' Association, the official state-wide organization of the great industrial interests of Ohio.

In voicing their regret at his relinquishing the positions he has held with the State Medical Association for the past 16 years, their appreciation of his meritorious services, and hearty best wishes for the future, the Council and officers of the State Association, have expresed the unanimous sentiment of the membership of the Ohio State Medical Association.

The medical profession of Ohio congratulates our friends of the Ohio Manufacturers' Association on having acquired the services of the best qualified organization executive in Ohio.

Sorry as it is to lose the services of Don K. Martin, the medical profession is proud that the industries of Ohio in their search for the most competent man in Ohio have paid a high tribute to medical organization by selecting the man who had so much to do with establishing and maintaining medical organization on an efficient and effective basis.

Those who have been closely associated with Don K. Martin in the activities of the Ohio State Medical Asociation and have been in an opportune position to know of his exceptional qualifications, his keen judgment and insight with respect to economic, legislative and legal questions, his loyalty and devotion, and the many other commendatory characteristics with which he is endowed, are confident of his success in his new field of organization activity.

Don K. Martin's record as executive secretary of the Ohio State Medical Association is exemplified in the numerous splendid achievements of our organization during the past 16 years.

The Journal, as the official voice of the medical profession of Ohio, takes this opportunity to express to him on behalf of the physicians of Ohio their warm appreciation for the services he has rendered them and the public at large, and to wish him every success attainable in his new position and field of activity.

—OSMJ—

"Will America Copy Germany's Mistakes?"

"The medical profession disapproves of the proposed law because this method of handling medical care is damaging to the patient and disastrous to the doctor," declared Dr. Arthur J. Bedell, president of the Medical Society of the State of New York, in a statement to the New York State Legislature in opposition to a compulsory sickness insurance proposal now pending before that body.

Dr. Bedell emphasized the observation that "the acid test of experience condemns compulsory health insurance schemes wherever they have been tried".

He quoted extensively from a report written and translated for the Pennsylvania Self-Insurers Association, Philadelphia, by Gustav Hartz, labor economist of Berlin and author of several books on Germany's social politics.

Dr. Bedell's advice to members of the New York Legislature was that they heed the implied warning of the caption of the report—"Will America Copy Germany's Mistakes?"

Some of the important points raised by Hartz are to be found in the following excerpts quoted by Dr. Bedell:

"Sick insurance provides the workman with medical attendance free of charge, with medicine and other necessities, and with an allowance. Anyone will at first sight consider this a great blessing for the workman as well as for national health. The reality, however, is far different.

"The insured workman becomes a second class patient. The mass demand compels a limitation

in the use of medicines. Doctors must not prescribe what they consider good for the patient, they are only allowed to give remedies entered in a book of medicial regulations for insurance purposes.

"Dread of illness obsesses most people and this has been pressed into a system 'illness made easy' by which the will to be well is strangled. The doctor is consulted a dozen times where once would be sufficient—the insurance pays. The prescribing of medicine and bandages is desired. When they have been obtained they lie about until they are no longer fit to be used—the insurance pays. Besides it is nice to get something in return for the premiums paid year in and year out. There is developed a fear of illness which shakes the will for recovery—the best aid to health. Pretenders and hypochondriacs are bred and the use of medicine becomes excessive.

"Medical science has become a cheap article and doctors have given up conscientious treatment. The genuine patient is neglected, is not given the necessary care. The greater the mass consultation, the lower are the doctor's fees. They are, therefore, compelled to resort to mass practice.

"All this is at the workman's expense, for the part of the premiums supposed to be paid by the employer is in reality borne by the workman either as a consumer or wage earner. As the employer's premium share is immediately connected with the wage, it is shifted over on the wage. In Germany, no one any longer doubts the fact that the employer's share of the premium is taken from the workmen's wages. What the employer pays as his contribution, he cannot pay the workman in the form of wages.

"A network of deception has been spread. In millions of cases wrong was turned into right and the gates opened wide to fraud. When wages are being decreased, when work is scarce and work hours shortened, when there are fewer shifts, many holidays, sick insurance comes in handy. One objects to the work he is given, another does not feel like working. Matters soon make an extensive controlling system necessary. This ends in badgering all persons.

"Patients are visited in their homes by controlling officials who have to convince themselves that the patient is really ill and not doing any work. The sick insurance engages so-called confidential doctors who have to submit the patient to a final examination to see whether he is too ill to work. The results of such examinations are to a great extent startling. Here is one instance from among thousands: 2008 patients were ordered to appear for a final examination. Eight hundred sixteen of them at once declared their complete recovery; 289 were found to be well by the confidential doctor. So nearly half of them were not ill at all.

"The confidential doctor is, so to say, the medical policeman, who not only controls the patients but also his fellow doctors who are treating them.

"The genuine patient is justly indignant to find that the existence of his illness is doubted, and that he who has always paid his premiums regularly and has a right to demand conscientious attendance, is considered a cheat.

"This system, together with the rest of the bureaucratic apparatus, has wedged itself between doctor and patient, completely destroying the patient's confidence in his physician, which greatly retards all recovery.

"Those who know anything about the actual working of compulsory health insurance will not be surprised that the confidential doctor, whose task it is to keep the number of patients low, may declare a patient recovered, who nevertheless dies two days later."

—OSMJ—

Employment, Fair Wages and the Public's Health

The year 1934 established a new record for low mortality among the many millions of industrial policyholders of the Metropolitan Life Insurance Company, according to a recent issue of the *Statistical Bulletin* of that company.

The bulletin points out that the crude death rate (ages one and over) dropped to 8.33 per thousand from 8.41 in 1933, and that when correction is made for the higher average age of the policyholders last year, the drop was still greater, from 8.03 in 1933 to 7.87 in 1934, a decrease of 2 per cent.

Commenting on this situation, the Metropolitan's statistician makes this interesting observation:

"These new minima show very clearly that health conditions have been maintained on a very high level among insured wage earners and their families in the United States and Canada. It is particularly noteworthy that among this insured group the downward trend of mortality over more than two decades has not been interrupted during five years of economic disturbance."

It will be observed that this remarkable record was made among a group of persons classified as *wage earners*, which would seem to indicate clearly that public health conditions in general are largely controlled by whether or not people are employed and earning sufficient to provide reasonable and necessary medical care for themselves and their families. In other words, the state of the public's health is an economic problem as well as a medical problem. Unemployment and reduced earning power are factors which must be considered in analyzing reasons for increases in mortality and morbidity rates.

The present agitation for radical changes in methods of providing medical care through the establishment of socialized schemes or systems of government-controlled sickness insurance is an outgrowth of the long period of economic depression. When men are employed and wage scales were on a higher plane, little or no dissatisfaction over the existing plan of distributing medical care was apparent. The condition of the public's health generally was good. The Metropolitan's survey shows that these satisfactory conditions have prevailed to a marked degree throughout the economic disturbance among those who have been able to retain employment at reasonable wages.

Radical changes in the present methods of

meeting the medical and health needs of society will not solve the fundamental difficulties with which many persons now out of a job and earning nothing are now confronted. General improvement in economic conditions, providing employment for all employables, and elevating wages to a place where the employed can live with reasonable comfort will provide most people with the means to obtain competent medical service for themselves and their families from physicians of their own choice and on conditions worked out between themselves and their physician.

—OSMJ—

Witte Denies Connection With Epstein Proposal

Under date of February 19, 1935, Mr. Edwin E. White, executive director of the President's Committee on Economic Security which formulated the social insurance report on which proposed legislation now pending in Congress is based, communicated to the editor of the *New York State Journal of Medicine* requesting a correction be published relative to a statement made in an earlier issue of that publication to the effect that Mr. Witte was one of the persons who assisted in drafting the health insurance bill of the American Association for Social Security.

"This is an entirely false statement," wrote Mr. Witte. "I had nothing to do with the drafting of this bill and was not consulted in any manner; in fact I did not know that such a bill was being prepared until I received a copy thereof. As your statement put me and this Committee in an entirely false light before your readers I shall expect you to make prompt correction."

At Mr. Witte's request the correction was published in the *New York State Journal of Medicine.*

To those who have read the so-called Epstein health insurance bill which was formulated and is being promoted by the American Association for Social Security, there is some consolation in learning that apparently those advising the Federal Administration on social legislation and activity engaged in formulating proposals to bring it about are not keen about the Epstein measure and do not consider it a compliment to be mentioned in connection with it.

It is hoped that Mr. Witte and his associates will continue to shun any connection with plans and proposals such as the Epstein bill, and endeavor to maintain a sane point of view in considering suggestions for Federal legislation pertaining to medical and public health services and heed the sound advice of informed and conservative members of the medical profession, based on the concerted medical viewpoint on these questions.

Meritorious Activity of A. M. A. Council on Pharmacy

Of more than passing interest was the commemoration on February 11 of the 30th anniversary of the Council on Pharmacy and Chemistry of the American Medical Association.

The Council on Pharmacy and Chemistry has made contributions of great value to sound therapeutics in this country. Four of its present members have been active in the work of the council since its organization.

A comparison of the conditions prevailing in the marketing of drugs in this country before 1905 and those today indicates the debt that those vitally interested in scientific medicine and public health owe to the Council on Pharmacy and Chemistry. The council always has stood for accuracy and truthfulness in the marketing of drugs and medical products. It has kept pace with the times, revising its rules and regulations frequently to meet new conditions. Its activities have had an important effect in curtailing quackery and fraud.

For many years the *Ohio State Medical Journal* has accepted no advertising from drug and pharmaceutical houses unless the products they sought to advertise were accepted and officially approved by the Council on Pharmacy and Chemistry. For that reason, the accuracy of the statements made by the advertisers in *The Journal* has been assured. Advertisers in *The Journal* deserve the support of the membership of the State Association and should be given preference by Ohio physicians in the purchase of pharmaceutical supplies and in recommendations to patients.

The Council on Pharmacy and Chemistry should have the ever increasing support of the medical profession generally. Without it, medicine and the public would have suffered. Its militant activity in the future is highly essential.

—OSMJ—

Education And Membership

At the recent annual meeting of the Association of American Medical Colleges at Nashville, Tenn., part of the program was devoted to a discussion of the importance and value of a closer cooperation between the medical school and the state board of licensure.

In the opinion of Dr. H. M. Platter, secretary of the Ohio State Medical Board; Dr. I. D. Metzger of the Pennsylvania board; Dr. Harold Rypins of the New York board, and others who took part in the discussion, many of the problems which have arisen in the field of medical licensure can only be solved with the assistance and cooperation of the medical schools of the country which in the first instance

are charged with the responsibility of preparing the young physician to meet the requirements and discipline of licensure.

Here is another splendid illustration of the inter-related responsibilities and obligations existing among all agencies directly interested in the field of medicine. None can serve its purpose well unless it has the assistance of the others. None can function effectively as an independent factor, giving little or no consideration to the activities of allied groups.

For example, medical organization in order to function effectively and efficiently must have the cooperation of medical schools, boards of licensure or other official agencies which are a part of the whole field of medicine.

Needless to say, the medical school can and should perform a very important function in maintaining medical organization as a potent factor in medicine.

The undergraduate who is given an opportunity as a part of his medical training to learn something about the purposes, activities and benefits of medical organization is potentially a valuable member of medical organization.

He is quite likely to take a greater interest in the activities of organized medicine and therefore reap more of its benefits following his graduation than the student whose education on this important phase of active practice has been neglected.

One of the primary objects of medical education today is to develop a higher sense of responsibility in the medical student.

Instruction to develop this responsibility should include some reference to the responsibility each physician owes to his colleagues and to the advancement of the profession as a whole.

The medical school is remiss in fulfilling its obligations to its students unless it formulates some procedure to inform them as to the value of medical organization in developing understanding between physicians, promoting scientific advancement, safeguarding public health, maintaining high ethical and educational standards, and stimulating harmonious and concerted action on matters beneficial to the physician as an individual, the profesison generally and the general public.

Every instructor in every medical school has an unusual opportunity to become a missionary, as it were, on behalf of medical organization. To enkindle an appreciation of the value and importance of medical organization among those who ultimately will be expected to carry on the work of organized medicine and by so doing share in its benefits, should be one of the objectives of all who teach or have contact with medical undergraduates.

Someone has said physicians are made, not born. The same is true of good members in organized medicine. The proper time to prepare the physician for usefulness in medical organization is when he is securing his training on other matters pertaining to the science and art of medicine.

— OSMJ —

Journal Puffed For Its Service To Membership

In the February issue of *The Journal* there was published a warning to Ohio physicians to purchase their insurance only from licensed, reputable companies and agents.

During the past month many trade journals and publications whose circulation is among business men generally have quoted extensively from *The Journal's* comment on this subject and have commented favorably on the sound advice given to members of the State Association.

One Ohio physician received the following letter from a general insurance agency in his hometown.

"Attached is a clipping taken from the February 8 issue of *The Journal of Commerce and Commercial,* New York. This article appears in the *Journal of Commerce and Commercial* as a result of the letter we wrote them.

"As a suggestion we think it would be advisable for you to send this clipping on to your state medical journal so that they will know what a great impression their insurance editorial has made.

"We have already heard from two other large insurance publications and it is their plan to run the editorial in future issues. Surely the members of your state association should appreciate the fine service they are receiving from your central office at Columbus and particularly through your trade journal."

The Publication Committee is not accustomed to blowing its own horn. However, it is proud of the *Ohio State Medical Journal.* It believes it is rendering a distinct service to the members of the State Association and has done so for many years. Occasionally, we get the feeling that some members do not fully appreciate this and do not give *The Journal* the consideration it deserves. To give the membership some idea as to how *The Journal* and medical organization in Ohio are regarded by those outside the medical profession, we have taken the liberty of publishing this complimentary correspondence.

This is only one of the many services to the membership rendered by *The Journal* and the State Headquarters Office. These benefits can be increased in proportion to the increase of active interest on the part of every member in the functions and programs of organized medicine and in cooperating with the Publication Committee on all occasions.

HYPERTHYROIDISM

By HARRY G. SLOAN, M.D.,

CLEVELAND, OHIO

WE shall confine our discussion to the acute crisis occurring in the course of thyrotoxicosis. This may develop spontaneously in Graves' disease or may follow a traumatic injury sustained by a goitre patient. Again it may follow an operation other than on the thyroid done on a person who has a thyrotoxicosis. Most commonly the crisis, however, follows thyroid operations done for the relief of exophthalmic goitre.

Hyperthyroidism was the term formerly given to this syndrome—of high fever, rapid pulse rate, increased metabolic rate, heightened blood pressure, great restlessness and mental confusion. We prefer the term thyroid crisis because we do not know its cause.

The blood iodin studies of Von Fellenberg, Veil and Sturm, Bier, Lundy, and in this country of Curtis and Davis, show that the iodin content of the blood is increased in exophthalmic goitre. Bier, Lundy, Curtis and Davis have shown the blood iodin in Graves' disease is immediately reduced following sub-total thyroidectomy. The iodin normally found in the blood is composed of 65 per cent in organic combination and 35 per cent in inorganic. The organic part is assumed to be thyroxin. We, however, have no proof of this. Lundy of Oslo reports that the organic fraction is increased in Graves' disease.

Dr. Tichy and I tried last Winter to show the presence of excess thyroxin in exophthalmic goitre blood. We hoped to prove by Asher's rat test that following bilateral lobectomy for Graves' disease that the circulating thyroxin was reduced in the blood serum—in other words, to confirm the reported blood iodin findings following thyroidectomy for this disease. We selected five patients whose basal metabolic rates were between plus 65 and plus 74. The tests were made before they had received iodin in preparation for operation. No blood iodin determinations were made on these patients.

Asher has shown that if rats are fed thyroid extract they become more susceptible to lessened oxygen tension than normals. The fed rat is placed with his normal fellow control in a bell jar where the oxygen tension can be gradually lowered. As the oxygen tension is reduced from atmospheric pressure, which is 740 mm. of mercury, to 350 mm. in from 10 to 15 minutes, then the rat fed thyroid constantly and clearly shows his distress by respiratory increase and by the incoordination of his movements, in comparison with the normal, which is unaffected by this reduction in pressure. Asher showed that this effect was due solely to the decreased oxygen and that barometric pressure did not play any role. The rats fed thyroid were shown to have an increased B.M.R. by micro methods. Reduction of oxygen tension proved crucial with them.

Our rats were injected with 2 cc. of the patient's blood serum. This dosage was repeated three times on alternate days and the rats were tested on the sixth day after the first injection. The highest total amount of serum iodin that would be given in three injections of 2 cc. each would then amount to hardly 6 gamma of iodin. Rats fed 65 mg. of thyroid extract per day for a week would receive 166 times this amount. We were unable to show any difference in the way the injected rats reacted from the normal controls when we subjected them to decreased oxygen tensions. As a check, we then injected a series of rats with a solution containing thyroxin prepared freshly for each injection. Thyroxin is 65 per cent iodin. This solution contained 100 gamma of iodin to the 100 cc., a higher iodin concentration than found usually in thyrotoxicosis. The rats were given 2 cc. of this solution on alternate days for three doses and were then tested on the sixth day after the first injection. None of them showed any change from the normal controls when subjected to decreased oxygen tensions. We were therefore unable to confirm the findings of De Quervain's pupils who reported that rats injected with serum from thyrotoxic patients showed a heightened susceptibility to decreased oxygen tension. Our experiments showed that Asher's test is not sufficiently delicate to detect such small amounts of thyroxin.

The cause of thyroid crisis is not known. It is comparable to the reaction that follows surgical removal of a parathyroid adenoma, with the resulting tetany. This can be relieved by the injection of parathormone, the active principle of the parathyroid gland. This crisis is one of deficiency. Another comparable reaction is that following surgical removal of an adenoma of the adrenal cortex for the cure of the genito-hirsute syndrome caused in children by such a tumor. The adrenal crisis can be relieved by the injection of cortin, the active principle of the adrenal cortex. One might argue likewise that the post-operative thyroid crisis would be relieved by substituting the active principle of the thyroid. But one sees thyroid crises developing in Graves' disease when no operation has been done and when none of the thyroid, the factory of thyroxin, has

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been removed. Whether the crisis is due to the deprivation of circulating thyroxin we are not prepared to say. It is doubtful. Removal of a normal thyroid gland from man does not cause a thyroid crisis. Why the syndrome is favorably affected by substitution therapy is equally mysterious to us. The question of dysthyroidism comes up. Is it possible that under abnormal stress a poisonous suboxidized thyroxin is elaborated? We do not know.

Experiments by Krough and Lindberg, in feeding thyrotoxic glands to guinea pigs and comparing the changes in metabolic rate, show: that the difference in rate is dependent entirely on the iodin content of the glands fed and had no relation to the type of gland fed, whether exophthalmic, colloid or adenomatous.

We recognize the thyroid, pituitary, and adrenal components in exophthalmic goitre. The proportion of each component varies with each individual. The problem is very complicated.

Clinically we have seen marked improvement in the post-operative thyroid crisis following within twelve hours of the giving of G 2. of thyroid extract by rectum. Asher has shown that thyroxin given intravenously started to act in four hours.

Our first experience in thyroid substitution therapy happened in 1917. Mrs. B. was suffering from a severe type of Graves' disease. We ligated both upper poles and she returned for thyroidectomy three months later. She, however, had gained no weight. Bilateral lobectomy was carried out without incident, her pulse rate at the end of operation ranging 100. Ten hours later she was comatose, temperature 41°, pulse rate so rapid and irregular in force and volume as to be hardly countable. We had been giving considerable thought at that time to the possibility that the crisis might be the result of acute deprivation of the active principle of the thyroid which was caused by the removal of so much gland. She was given a retention enema of G 2. of powdered thyroid extract in 300 cc. of water. Twelve hours later she was entirely conscious and made an uncomplicated post-operative convalescence. We could account in no other way for her remarkable recovery unless it had been caused by our thyroid extract medication.

But this substitution therapy is not the whole answer to thyroid crisis. In thyrotoxicosis the entire body structure is affected by the disease—skin, muscles, bones, viscera, the central nervous system, even the blood. In the blood the albumin globulin partition is altered, hence the benefit of blood transfusion post-operatively to bring this relation back nearer to normal as well as to supply red blood cells for the better transportation of oxygen. The oxidation of the body is enormously increased.

May it not be that the fixed tissue cells of the body whipped into activity by the excessive thyroid stimulation, finally, and as a result of the jolt of operation, or in the course of the severest type of the disease, really run wild and burn up the patient by their combined activity? This may be the explanation of the importance in avoiding, during operation, any insult to the organism by using local wound block and giving the least amount of damaging anaesthetic.

During a crisis one has only to note the increased respiratory rate and the bluish tinge of the lips to realize that the organism is crying for more oxygen. It is most gratifying to note the complete change in the patient's appearance when he is put into a tent where the oxygen content of the air can be held at 50 per cent. The agitation changes to tranquillity, a restful expression replaces the look of anxiety, the color of the skin changes to a healthy pink and the patient often falls asleep.

Since the pre-operative preparation with iodin has been in vogue we rarely see these thyroid crises. They do occur, however. They happen more frequently in the older patients where the thyrotoxicosis is of long standing and where marked weight loss has resulted. Then, too, there are those who are iodin resistant. These continue to lose weight, even under bed rest, high caloric feeding, large fluid intake plus the giving of iodin. Such patients can usually be shown to harbor an active focus of infection. When, under pre-operative preparation, an infectious focus flares up in one of these exophthalmic goitre patients, as, for instance, the developing of an abscessed tooth or an intercurrent tonsillitis, one sees an activation of the disease—a mounting basal metabolic rate, the softening of the thyroid already made firm by iodin, increased pulse rate, with fever and a resulting weight loss. Weight gain is the most important index of improvement in thyrotoxicosis whereas a continuing weight loss while the patient is under observation is of grave import in deciding the time and type of operation.

We showed in 1930 that amytal given in exophthalmic goitre cases in doses of 15 mg. per kilogram reduced the basal metabolic rate 50 per cent for several hours. Larger amounts of the barbiturates are needed to give physiological action in this disease than in normal people.

Twenty years ago Dr. Crile proposed packing a crisis patient in ice to control the fever. He was one of the earliest advocates of large fluid intake following thyroidectomy.

Today we are still in the shot gun prescription stage in caring for the thyroid crisis patient, yet every year yields some valuable addition to the curative means at our disposal. Clinical experience has proved our best teacher in surgical judgment. Often when one expects trouble it does not come, and, again, it may come when least ex-

pected, so, as Kipling says: "you're as like to be wrong". When we are suspicious that a thyroid crisis may occur following operation we treat the patient prophylactically.

1. Our routine is to have the patient adequately prepared with iodin.

2. We then make a careful selection of the procedure to be undertaken, as to when and what it is safe to do surgically.

3. We plan to do even less operating than we feel the patient will bear.

4. We give thyroid extract or thyroxin post-operatively.

5. Iodin is also given post-operatively.

6. We aim to give 4000 cc. of fluid in the next 24 hours following operation, 1000 cc. of this being 5 per cent glucose, which is given by vein.

7. Quiet is induced by morphine and penta barbital. These drugs are synergistic. Penta barbital is the most efficient and least toxic of the barbiturates.

8. If the temperature goes above 39° rectally we pack the patient in ice bags.

9. Transfusion of whole blood aids in the emergency.

10. If we are suspicious that the post-operative course will be stormy we immediately after operation place the patient in an oxygen tent—this is started at once, not waiting for the storm to develop.

1412 EUCLID AVENUE.

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MENIERE'S SYMPTOM COMPLEX. MEDICAL TREATMENT

By A. C. FURSTENBERG, M.D., F. H. LASHMET, M.D., and MR. FRANK LATHROP,

ANN ARBOR, MICHIGAN

SINCE the classical description of Meniere's Disease was given to medical science in 1861, much speculation has occurred and many pertinent recommendations have been made, referrable to the treatment of this symptom complex. For many years the therapeutic management of this malady has been a controversial matter and one in which a confusing number of remedies have been offered, based chiefly upon the hope that they might in some manner influence some of the many hypothetical, pathological changes which are assumed to exist.

The sum total of these endeavors has been of little value to the patient and the causes of failure are clearly those of trial and error. Assuming, for example, that an increased secretion of cerebro-spinal fluid is responsible for pressure upon the eighth nerve, the lumbar puncture is advocated. Or, considering the pathogenesis associated with the sympathetic and para-sympathetic nervous systems, such drugs as pilocarpine, atropine and adrenalin are administered because of some pharmacological action upon nervous tissue. Recent studies in the field of endocrinology which suggest a possible relationship between a glandular dysfunction and epilepsy, the latter seeming to be akin to Meniere's disease, have occasioned an investigation of the patient's calcium metabolism and prompted the use of thyroid, parathyroid and pituitary substances. Quinine, for its specific effect upon the auditory nerve, potassium iodide, for its empirical values, bacterins and vaccines for what they may be worth and finally, the application of a seton to the nape of the neck, are the remaining therapeutic measures available for trial.

Theoretically, some appear to have merit. We do not doubt the value of lumbar puncture in certain cases of vertigo. The effect of free catharsis and pilocarpine sweats has properly given rise to much enthusiasm in others. These measures conceived in good faith have been promoted by an honest conviction that they have cured certain individuals of an intractable vertigo and that they are capable of doing the same for others. Yet who has not applied this large group of therapeutic possibilities only to end with a feeling of futility and a sense of despair. The lack of sustained practicability of medical therapy is constantly in evidence and presents an appealing problem to those who are endeavoring through clinical research, to extend the boundaries of

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specific therapeutics. Lest our claims appear presumptuous, may I add that the conclusions derived from our own studies are probably no exception to this fact.

There are other obvious reasons for the bewildered and futile state of medical therapy in Meniere's symptom complex. Consider, for example, the enormous variety of vertigo syndromes to which medical treatment has been applied. The tendency to create a disease entity by grouping a number of cases having one symptom in common is one of the temptations of medical practice. Vertigo lends itself admirably to this evil. Every conceivable form of dizziness appears to have been classified as a disease and treated as such. Failure to designate disease entities properly and apply well directed treatment has made a correlation of results impossible. There exists, therefore, no uniformity of opinion in respect to the merits of the innumerable therapeutic measures which have been employed.

The point of the foregoing is that many otologists have made their own classifications of Meniere's symptoms complex. They have done so whimsically and without consideration of the scientific facts upon which a clinical entity is developed. It has been a term loosely applied and much abused. So much has this been true that many authors have urged abandoning the personal reference and the acceptance of a more precise nomenclature. No matter what justification may exist for such a change, it remains a fact, nevertheless, that the great French clinician described a syndrome definitely related to the acoustic nerve and one which has borne his name for nearly three-quarters of a century. I strongly suspect that future generations of our profession will continue to accord it this personal reverence.

Consider the syndrome which is typically Meniere's symptom complex: It embodies well defined clinical manifestations which have been exhaustively treated in our medical literature and are well known to every student of otology. A simple glossary will suffice to enumerate and place on record the symptoms which characterized the disease as it was treated in the following studies: A violent attack of vertigo in a patient with deafness; occasionally impaired cochlear function on both sides, but more profound in the ear to which the symptoms are referred; nausea, vomiting and spontaneous nystagmus in the severe seizures; persistent tinnitus—often bilateral—increased during the paroxysm; vestibular tests of little significance—usually within the limits of normal; a pathetic picture of total disability in an individual suffering from a vertigenous attack, or living in the terror of an impending one.

The pathological changes responsible for the capricious symptoms of this syndrome still remain a mystery. They have been the subject of numerous studies, varying from conscientious research in the pathological physiology of the auditory mechanism, to skillful adaptations of morbid processes to meet the clinical needs. They comprise voluminous works in our medical literature, quotations from which at this time would merely constitute a repetition of medical history. Suffice to say for those who hold that the pathological changes are in the internal ear, that statistical evidence indicates that the destruction of the otic labyrinth in a few cases has not been followed by relief of symptoms.

To those who refer the morbid changes to the auditory nerve, I might add that microscopical examination of sections from the acoustic nerve in eleven cases failed to demonstrate pathological alterations in the tissue submitted for study. In nine of the cases, relief immediately followed section of the nerve. In two of the cases the symptoms are still present after periods of two and four years. Dr. Konstantin Lowenberg, pathologist in our Psychopathic Department, in a recent study of autopsy material from a fatal case of tumor of the acoustic nerve, has made an extraordinary observation in the discovery of a normal nucleus in the presence of a completely degenerated auditory nerve. This amazing phenomenon, if sustained by further studies, would suggest an innervation of the nucleus from the opposite side and offer another site in the auditory system where the influences of pathological changes might be felt. Obviously a nuclear lesion under such conditions would not be affected by section of the auditory nerve, and herein may lie a possible explanation for the failure, in rare instances, to obtain immediate and complete relief following severence of the acoustic nerve.

It is doubtful, therefore, if the clinical manifestations of Meniere's symptom complex can be definitely ascribed to any isolated part of the auditory tract. Rather is it more accurately assumed, perhaps, that any or all of its constituents may participate in the changes which give rise to a typical attack. There is some proof for this assumption in the observations already recorded, while the conclusions derived from our own studies do not tend to detract from this belief.

The thought which gave rise to the following investigation was derived from the observation that patients with Meniere's symptom complex were occasionally relieved by a course of pilocarpine sweats. Was this effect the result of dehydration in a patient with a local edema of the tissues involved in the production of the syndrome, or did the water excreted from the body carry with it certain elements which were responsible for the disease? The suppositions

seemed tenable and with these in mind, the co-operation of Dr. Newburgh and Dr. Lashmet was solicited and a study of the metabolism of water in patients afflicted with the disease was started.

It was quite obvious that if an accurate statement of water exchange was desired, the amount of water into the body from every source and the amount of water out of the body at every exit must be determined. Other investigations along this line had been previously made but in each instance only the free water taken into the body and that eliminated as urine was considered. As will be seen only a small fraction of both the water into and out of the body could be determined by such a means.

Table 1 lists the various items of water "into" and "out" of the body and gives the average amounts of each as obtained under ordinary conditions with the normal subject. Examination of this table reveals several interesting facts.

TABLE 1—WATER EXCHANGE—BALANCE

Available water	Grams	Excreted water	Grams
1. Exogenous		3. Urine	1000
A. Diet	900		
B. Water as such	1100		
		4. Stool	200
2. Endogenous			
A. Oxidation	200		
B. Preformed	0	5. Vapor	1000
Total	2200	Total	2200

The water contained in the solid food of the diet is a relatively large amount. The quantity of water derived from the oxidation of protein, fat and carbohydrates, although relatively small, is not slight enough to be neglected. The "preformed" water which is that water released from body tissue when the latter is destroyed, is absent when the subject is in energy balance, and therefore, is of no significance here. Finally, the most interesting fact is that the "water as such" or the free fluid of the intake constitutes less than 50 per cent of the total water available to the subject.

In considering the various losses of water from the body, a most surprising amount is lost by vaporization from the skin and lungs. This loss is comparable to the amount of water lost as urine, and is rarely determined by those pretending to measure water exchange. The water contained in the stool is relatively small but it is apparent that it, too, must be determined in an accurate water exchange. The water of the urine is the one loss most commonly determined, but it constitutes less than 50 per cent of the loss of water from the body. The quantity lost by vaporization is often greater, although it has seldom been considered in studies of water exchange.

It must be obvious that determination of the free fluid of the intake, and the urine volume constitutes less than 50 per cent of the total exchange of water by the body. Consideration of only these two items of water exchange often results in erroneous conclusions regarding the status of body water. The following examples (Tables 2 and 3) are given to demonstrate this fact. Table 2 shows the data obtained from a post-operative case of acute intestinal obstruction. If one compared only the "water as such" (3000 grams) with the urine water (700 grams),

TABLE 2—WATER EXCHANGE—DEHYDRATION

Available water	Grams	Excreted water	Grams
1. Exogenous		3. Urine	700
A. Diet	0		
B. Water as such	3000	4. Stool	750
		5. Vapor	1000
2. Endogenous			
A. Oxidation	225	6. Emesis	1500
B. Preformed	200		
		7. Drainage	750
Total	3425		
Daily dehydration	1275	Total	4700

the daily dehydration of 1275 grams would never have been suspected. Table 3 shows the data obtained from a subject having chronic nephritis and oedema. If, in this subject, one compared the "water as such" (1200 grams, which is smaller than that of the subject in Table 2) with the urine water (800 grams, which is larger than that of the subject in Table 2), the daily accumulation of 550 grams of oedema would have been overlooked.

TABLE 3—WATER EXCHANGE—HYDRATION

Available water	Grams	Excreted water	Grams
1. Exogenous		3. Urine	800
A. Diet	900		
B. Water as such	1200		
		4. Stool	150
2. Endogenous			
A. Oxidation	250		
B. Preformed	0	5. Vapor	850
Total	2350		
Daily hydration	550	Total	1800

The foregoing facts make it evident that such investigations are of value only when a method which insures a more accurate determination of water exchange is employed. The data presented below is the result of such an investigation.

Time does not permit a detailed account of the procedure by which an accurate statement of water exchange was obtained in this investigation. (For these details, reference may be made

to the original, descriptive articles (1)). However, the following brief description is given in order to emphasize the care and precision which are imperative in such a study.

The subject was weighed in the nude state at definite intervals of either 12 or 24 hours on a special balance which is accurate to 1.0 gram. The drinking water ingested daily was accurately weighed in a large thermos bottle from which the patient drank through a glass tube. Throughout the experiment, the diet was constant, the same kinds and amounts of food being ingested day after day.* The food was prepared, accurately weighed and even served by one of us. The water content of the food was determined by desiccation. The urine and stool were collected daily in closed pails, acurately weighed and the water content of each also determined by desiccation. The daily excretion of nitrogen was obtained by Keldal analysis of the urine and feces. The water lost by vaporization from the skin and lungs, and that available from the oxidation of the food stuffs, was obtained by means of the insensible loss of weight and the metabolic mixture as described by Newburgh, Wiley and Lashmet. (1)

Thus, in this investigation, the water exchange was determined by quantitatively measuring every item of water "into" and "out" of the body.

The data presented herewith, was obtained from a patient who had had typical Meniere's disease for ten years. For about two years prior to this study, he had averaged two or three attacks per week, and for the six months just past had suffered a daily seizure. These attacks were characterized by a "feeling of fullness" in the head, "buzzing and ringing" in the ears, dizziness and finally, nausea with vomiting. The only relief he had been able to obtain was secured by lying very quietly with eyes blindfolded.

For the first six days of this investigation, water exchange was determined for periods of 24 hours. It was soon realized that changes in body water occurred so quickly that 12 hour periods of determination were necessary. Consequently, for the remainder of the study, water exchange was measured for periods of 12 hours, one period beginning at 7:15 A. M. and ending at 7:15 P. M. and the following period beginning at 7:15 P. M. and ending at 7:15 A. M.

The first five days were used as a control period, in an attempt to estimate the status of body water. The subject received the constant diet, as already described, and was permitted to drink water freely. During the first two days there was considerable retention of body water, half of which was lost spontaneously in the following three days. There were no attacks during this period.

On days 6 and 7, the subject received 348 milli-equivalents of sodium (87 m—eq. in the diet and 261 m.—eq. as sodium chloride), administered daily during the 12 hours while awake. For the first 36 hours there was a marked retention of water in the body. A very severe attack, as previously described, occurred at the height of hydration. During the following 12 hours there was a spontaneous loss of water with a distinct diminution in the severity of the symptoms. During the first 12 hours of day 8, the subject ingested 261 milli-equivalents of sodium (87 m.—eq. in the diet and 174 m.—eq. as sodium bicarbonate.) Again, there was a marked hydration with a second attack occurring at its height. During the following 12 hours, all of the water which had been held during the preceding 12 hours was released and the subject again improved. It will be noted that these two attacks occurred when sodium was administered and retention of water by the body was in evidence. Consequently, one cannot assume that either one of these factors is solely responsible for the attacks.

In order to study separately the effect of water, the subject was purposely dehydrated during days 11, 12, and 13, by rigidity restricting the intake of water. When the subject was dehydrated to a level at which he had previously had no attacks (control period) he was then given 261 milli-equivalents of sodium (87 m.—eq. in the diet and 171 m.—eq. as sodium bicarbonate), during the first 12 hours of day 13. A severe attack occurred, in spite of the fact that the body contained strikingly less water than it did when the attacks were absent (days 1 to 6 and 9 to 11). During the first 12 hours of day 14, the same intake of sodium was maintained and water was freely given. There was marked retention of body water, although no attack was produced. However, the following day (day 15), during which the same intake of sodium was maintained, a fourth attack occurred, but not until the subject had lost approximately 500 grams of the water previously stored.

Beginning with day 16, and continuing to day 23, the intake of sodium was only that contained in the diet (87 m.—eq.) Water was permitted and averaged about 1800 grams daily. Ammonium chloride, an acid-producing salt, was administered in increasing dosage. At first, water was retained but this was gradually lost. During the period of water retention, it will be noted that the amount of water held was practically as great as when sodium was administered, but attacks resulted when sodium was given, while none were produced by ammonium chloride. Since ammonium chloride administration is associated with an increased excretion of sodium, it is presumed that ammonium chloride failed to produce an attack because it prevented the retention of sodium by the body.

It is obvious from this data that attacks occurred quite independently of whether water was stored or lost by the body. Furthermore, attacks were produced by the administration of sodium, regardless of whether such administration was attended by hydration or dehydration. The acid-producing salt, ammonium chloride, did not produce an attack, in spite of the fact that it was at first attended by a retention of body water quite as great as that accompanying ingestion of sodium.

SUMMARY

It is assumed from our experiments that the symptoms of Meniere's disease are due to the retention of sodium by the body. If a sufficient

(1) Newburgh, L. H.; Wiley, F. H.; and Lashmet, F. H. Journ. Clin. Invest. 1931—10—703. Journ. Clin. Invest. 1931—10—723.

*The daily diet consisted of: Milk 600 gms; Cream (40%) 100 gms; cheese 100 gms; bread (whole wheat) 150 gms; puffed wheat 10 gms; grape fruit (canned) 100 gms; butter 60 gms; apple sauce 150 gms; sugar 10 gms. Such a diet contained: Nitrogen 9.7 gms; fat 154 gms; carbohydrate 188 gms; calories 2382; total solids 397 gms; sodium 87 mille equivalents.

supply of water is available it will likewise be retained, but this fact is not of primary importance. Apparently, the local tissues involved in Meniere's disease have either an increased avidity for sodium or an unusual sensitivity to it.

The therapeutic indications are: (1) to permit as small an intake of sodium as is possible and (2) to prevent the accumulation of sodium by the body. The former is easily attained by means of diet and the latter by the administration of acid-producing salts such as ammonium chloride. When these two factors have been controlled, the intake of water does not need to be considered.

We have successfully treated fourteen cases of typical Meniere's disease. Each patient was carefully selected in an effort to rule out any obvious lesion such as an acoustic nerve tumor or a suppurative process in the temporal bone, and every precaution was taken to eliminate psychical elements from this study.

While the number of patients is not large it represents a group carefully chosen from the cases available in our clinic during the past six months. Each patient was hospitalized for a period of 10 to 30 days or more and the efforts of two members of the staff and myself directed daily towards a careful clinical and laboratory study of the problems at hand.

It is of extraordinary interest to note that identical curves were obtained for all of the patients in this group. In not one instance did we fail to produce an attack by the administration of sodium and not once were we disappointed in obtaining complete relief by the medical therapy above described. The patient whose chart I have just presented has been without a seizure since ammonium chloride was first given to him on October 16, 1933, and similar results for shorter periods have been obtained for the remaining thirteen cases in the group.

We are fully aware that presumptuous claims for medical therapy cannot be based upon the meagre statistics herein compiled. It is not our wish that such an inference should be drawn. Rather do we desire to suggest a new etiological factor in the production of Meniere's disease and the hope that it may lead to further research in therapeutics.

Obviously a study of this kind leads to many ramifications in the field of clinical medicine and physio and bio-chemistry. With each original discovery, new problems for further investigation are brought to light. Innumerable questions promptly arise and critical suggestions are prone to appear. Both are invited. We ask for criticism with the hope that it will criticize the work which is presented rather than the problems which the study suggests.

TRICHINOSIS

By DR. FRANK J. DORAN, M.D.,
CLEVELAND, OHIO

CASES of trichinosis are relatively rare, this being the second case in sixteen years at St. John's Hospital, Cleveland, and the first verified by section of muscle. It emphasizes the point that by ahering to routine examination, the true diagnosis will seldom be missed, and that often elaborate laboratory expense is not essential.

SUMMARY OF THE CASE

The patient is an adult woman; about 65 years of age; single; engaged in supervising a home, who was seen at home on April 26, 1934. About a week before being seen, she began to complain of symptoms that suggested grippe. Instead of improving, the symptoms became aggravated and it was thought that a mild upper respiratory tract infection had been communicated to both eyes. On April 25, she was seized with a chill and her temperature constantly rose to 104 degrees. At this time, it was noted that her leukocyte count was thirty thousand and opinion was asked as to the presence or absence of an acute pulmonary lesion.

Examination revealed a woman, very alert, cooperative, complaining of burning of the eyes, inability to lift the lids because of swelling and general malaise. There was no neck rigidity. There was slight injection of the pharynx. There was no dyspnea. Pulmonary signs were negative except for a few medium, moist rales in both bases. Blood pressure: 140/90. Abdomen: Negative. Knee jerks could be elicited.

There was no Kernig or stiff neck. Urine was essentially negative. Routine blood examination was repeated and revealed thirty-two thousand white cells, of which 72 per cent were definite eosinophiles. As this finding, alone, suggested infestation with trichina spiralis, the eyes were examined more minutely, in spite of the inflammatory appearance, and the ocular conjunctiva was noted to be so edematous that it almost hung in folds. In spite of many leading questions, patient refused either to verify muscular tenderness or to give a history of previous muscular soreness, except a slight degree of limp, that had been noted for two or three weeks. There was absolutely no history of a gastro-intestinal upset or pork infestation; the patient stating that she was always very careful to see that pork was well cooked.

For this reason, the patient was moved to St. John's and a section of the pectoral muscle on the right side was removed. Many parasites were found encysted in the muscle and, in addition, the muscle showed signs of cellular infiltration, as well as areas where the muscle seemed to be destroyed without cellular reaction, as though some lytic process were going on.

At the present time, the patient is convalescing, ocular edema has disappeared, no symptoms are left excepting a very low-grade temperature and a general feeling of prostration. Little weight has been lost. White blood count has fallen to sixteen thousand, eosinophiles at present numbering 25 per cent.

DISCUSSION

In view of the accepted figure that 1 to 6 per cent of hogs are probably infested with a trichina, and in view of the fact that only rarely do we encounter acute trichinosis clinically, the question arises whether many cases are overlooked and called "grippe" or "muscular rheumatism" or "mild gastroenteritis". The important finding in this case was a leukocytosis with a high eosinophilia. It pointed to the fact that the individual could be severely infected and acutely ill, without the usual syndrome of acute gastro-enteritis and prolonged muscular soreness and tenderness. It emphasizes again the fact that there may be no parallel between the clinical manifestations of disease and the actual pathological finding in the laboratory or post-mortem room. Here we have definite pathological evidence of an acute myositis with neither tenderness and pain nor spasm.

It is believed that this patient has passed beyond the danger point and will unquestionably recover, probably with little or none of the rheumatic-like complications. Her treatment has been practically symptomatic and on the basis of the treatment of typhoid. It was felt, with the experimental work done on animals with the serum of human convalescent patients, that many of the symptoms, for instance, the oedema of the eyes, might be an allergic reaction; therefore, that individuals who are properly supported develop an immunity against the toxin liberated by the larvae themselves or by the muscle in its process of dissolution. Therefore, high caloric diet has been maintained with satisfactory response on the part of the patient.

In closing, it should be emphasized that the circumorbital oedema and oedema of the ocular conjunctiva may appear highly inflammatory; that eosinophilia may be the only finding and there may be few, or no, symptoms of infestation in the human.

1408 W. 65TH STREET.

TRAUMATIC NEUROSIS

By GEORGE T. HARDING, M.D.,

COLUMBUS, OHIO

TRAUMATIC neurosis is no longer a subject for neurologists. A medical, social, and economic problem, it is one of the most frequent conditions seen by the physician and surgeon who treats personal injury cases or practices industrial medicine. Practically every patient belonging to this group exhibits some manifestation of the neuroses following injury, and both the prevention and cure of this expensive escape from the responsibilities of life rest in the hands of the physician who first sees the patient. It is important that our present knowledge of the neuroses should be better understood by those members of the profession who are in a position to influence the neurotic processes in the early stages. Every physician should have a practical knowledge of present day conceptions of psychopathology. He should be able to recognize in the injured individual the signs of a neurotic predisposition as an aid in proper management of the case. The physician and surgeon of today must know the neurotic when he sees one.

No one will seriously question the statement that there has been a marked increase in recent years in the frequency of nervous and mental symptoms in injured workmen. To one who is familiar with present conceptions of the neurotic reaction this increase is not unexpected. Each year we see more classes of workmen and new types of injuries made subject to compensation laws. The recognition of the right of the injured person to choose his own doctor has brought about a wider distribution of industrial practice, and has doubtless contributed somewhat to this increase. The attitude of the public as reflected in jury verdicts, the influence of labor on the administration of Workmen's Compensation funds, the existing economic depression, are all potent factors in adding to the army of defeated men who, after injury, have become the victims of their own fears, anxieties, problems, and greed. Nor can we ignore the effect of the increasing complexity of modern life and the paternalistic tendencies of government upon the individual who is constitutionally predisposed to the neurotic escape.

In this paper we will discuss only those neuroses in which there is no organic background of injury to the central nervous system. We will omit those neuroses which follow severe head injury and in which there is a possibility of an organic encephalopathy, although from a practical standpoint it must be recognized that it is not uncommon for a traumatic encephalopathy to be complicated by a functional nervous disorder of psychogenic or emotional origin. It is our purpose to show that traumatic neuroses, like the psychoneuroses which occur independent of injury, are real and not imaginary; that they are a mental disorder, and therefore subject to mental- or psycho-therapy.

HISTORY

Functional nervous disorders have been numbered among the ills of mankind for many cen-

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turies, and even before the building of the Temple of Aesculapius, unstable and exhausted housewives, baffled and injured men, sought and found healing in devotion to prayers and ceremony, the touch of an oracle, or the ritual of the medicine man. More recently we recall the establishment of shrines, the popularity of the modern Spa, the devotion of the general public to expensive magic "horse-collars" and the present craze for "Crazy Crystals", all of which testify to the continued existence of a quality of human nature which the medical profession has considered all too little and understood still less.

These functional nervous disorders, the cure of which, at shrines and by quasi-medical practitioners, most doctors scoff at, belong largely to the neuroses. Instead of recognizing the phenomenon and the means by which it is cured, we are inclined to dismiss it lightly and to think we have explained the whole matter when we attribute it to "suggestibility." In spite of this unconscious acknowledgment of the mental nature of the illness, we continue to treat its victims with surgery, medicine, body casts and braces, and ignore to a large degree the problem of mental treatment.

It is probable that in no branch of medicine have such marked advances been made since the beginning of the century as in the field of mental medicine. Our present knowledge and conceptions of the functional nervous disorders had their bebinning in the observations of Weir Mitchell, Kean, Da Costa, and others who observed the effects of the Civil War days upon farm boys hurriedly recruited for military service. During the later years of that same century many of the leading teachers of medicine spent much of their time debating and attempting to demonstrate pathology in the spinal cord because of a then frequent and familiar syndrome, "railroad spine," a condition which has disappeared under that name but is with us now as "traumatic neurosis." The turn of the century witnessed the birth of the new psychology and renewed psychiatry. Undoubtedly the contributions of Freud stand out among all others because of his "explorations of the unconscious."

In spite of these studies of the functional nervous disorders, the knowledge was so fragmentary and poorly understood that the beginning of the World War found the profession no better able to recognize these same functional disorders when they appeared in a new and different setting. It was some months after the beginning of the War before the British Medical Service prohibited the use of the phrase "shell-shock" because of the suggestion bound up in the use of a term which threatened to produce a complete loss of morale in the fighting forces. At first it was thought that "shell shock" was the result of concussion, the effects of high explosives, but the appearance of the condition in training camps where men were not exposed to shell fire soon led to understanding studies of the condition.

The present use of "traumatic neurosis" is no less demoralizing and unfortunate. "Railroad spine," "shell-shock," "traumatic neurosis," all convey the idea that the neurosis and the symptoms which characterize it are directly and entirely due to the occasion after which the symptoms appear. This in itself offers a serious obstruction both to treatment and the necessary explanation of the condition to the patient. Again, a diagnosis of "traumatic neurosis" lends a certain dignity, and encourages a sickness which would seldom be the subject of pride or boast if it were paraded under another legitimate term, "traumatic hysteria." But a far greater objection to the use of the term is the psychological handicap created by the suggestion to an already suggestible person, that the vague fears and nervous symptoms which he feels after his injury are directly due to physical effects of that injury, and that there is real damage to his person. The use of the term, "compensation-" or "litigation-neurosis" is obviously unfair to one who is familiar with the many elements which play a part in this condition, which in many cases might accurately be described as a "situation neurosis." We prefer to say, "psychoneurosis after injury."

WHAT IS A NEUROSIS?

It is more difficult to define a traumatic neurosis than to describe one. A traumatic neurosis is no different than a neurosis which occurs independent of injury. The word "traumatic" is only an indication of the occasion after which the symptoms appeared. Like all other neuroses, it is a mental sickness, as indicated by the accepted and frequently used term, "psychoneurosis." It is an adaptation, never entirely satisfactory, seldom successful in meeting the unsatisfied goal or ambitions, but like discontented husbands who find temporary escape from an unbearable situation by alcoholic indulgence, the neurosis often supplies temporary relief and may be necessary to preserve the personality. It is a product of heredity, early training, and environmental factors, of present fears and insecurity, as well as real or imagined personal gain.

With this conception of a psychoneurosis as an escape, a compromise or flight from reality, we can make use of the definition of Henry, who defines it as a "personality disorder in which instinctive and emotional differences are manifested under the guise of apparently unrelated mental and physical symptoms." We might say that the individual, confronted with troubling emotional problems, projects his worries so that they take physical and therefore demonstrable form. The relief to the individual is evident when one realizes that the worry which he could not explain, is obvious enough when projected as a monoplegia

or hysterical blindness, a condition which speaks for itself. However, not all of the projected functional disorders are so well localized, and the anxiety states, the vasomotor disturbances, the fatigue and discouragement, all of which arise from unhealthy mental representations and autosuggestions, are not so easily recognized and traced to the primary cause. But let it be understood that a psychoneurosis is not malingery.

Many are still confused by the terms psychosis and psychoneurosis. Both are mental disorders. Someone has referred to the latter as "the benign psychoses," but while no sharply defined boundaries exist between a psychosis and a psychoneurosis, there is a world of difference. In the psychoses the personality is so badly distorted that both the body and mind are abandoned to the demands of the sickness. In the psychoneuroses the personality is preserved by means of a surrender of the responsibilities and cares of life in favor of the individual's narcisistic and emotional demands. In a psychosis even a layman can recognize that something is wrong mentally. In a psychoneurosis the mental changes are usually unrecognized, since they permit the individual to meet the demands of his family and social life in a fairly acceptable manner although seriously disabling him for industrial usefulness. The psychotic person is usually an immediate problem in the home, but the neurotic individual acts as if reality had the same meaning as it does for the normal person. The change in the neurotic is quantitative rather than qualitative, and because he can still fill his accustomed place at the head of the dinner table and meet social demands in a fairly acceptable manner, the neurotic individual is seldom regarded as mentally sick. But he is.

WHAT CAUSES A NEUROSIS?

The real cause of the psychoneuroses are not to be found in the accidental happenings which provoke the acute symptoms. Most of us meet traumatism, illness, emotion, fatigue, every day, but with more or less voluntary resistance, we recognize that they produce no permanent effect on our health. On the other hand, the neurotic individual, conditioned by heredity, early training, or existing situations, over-reacts to these common experiences of life with an exaggerated emotionalism which is one of the stigmata of his type. It may be safely stated that the psychoneuroses do not occur except in the neurotic individual. At the same time, we must recognize that not all neurotics develop psychoneuroses.

The neurotic individual is one whom his friends refer to as "nervous." They recognize his difficulty in meeting his problems, as well as his inclination to exaggerate his fears and to prolong minor pains and ills. They see but do not recognize his suggestibility, his sensitiveness, the susceptibility to fatigue, and a peculiar selfishness that craves attention. As children these individuals show exaggerated emotionalism, meet new experiences painfully and with difficulty, have an unusual feeling of inadequacy and inferiority, show violent likes and dislikes, together with sudden but poorly sustained enthusiasms. We might mention the unusual fears of childhood, slow convalescence from illness, headaches, and hasty conclusions and lack of judgment which are always a source of unhealthy autosuggestions. But most of all there is the tendency to over-react to emotional and unpleasant experiences.

In addition to the hereditary element, which is quite important as a predisposing factor, we must recognize the part that unfavorable early home life, faulty habit training, poor educational advantages, and the conflicts of sex play as a background for a psychoneurosis. We need to recognize the danger of imitation of neurotic patterns in the family, for the family doctor all too often sees the neurotic habits, dislikes, and inability to eat certain foods passed down the line by a neurotic parent.

In those psychoneuroses in which there has been no trauma to serve as a precipitating cause, we most frequently find conflicts over sexual problems, marital crises, financial difficulties, and ill health or death in the family. In the traumatic neuroses these same factors are at work, and are often not only the predisposing, but the actual precipitating factor. In such cases the trauma is not even the occasion; it is the excuse for the development of the neurosis.

Too often the only psychic factors which the physician considers are those of litigation and the desire for compensation. A carefully elicited history or casual acquaintance with the patient will reveal other influences and causes, mental complexes, fear states and unfavorable influences. For some reason or other the importance of these influences is more often recognized in the nontraumatic neuroses than in those which follow injury, and there is an unfortunate tendency to drop the search when once a relationship to injury is established and a diagnosis of traumatic neurosis made. Even now the average physician seems to assume that some unexplained organic pathologic mechanism has created the neurosis rather than those fairly obvious causes which we see in the ordinary form.

We must not ignore, however, the part that trauma does play in the causation of these disturbances of neuro-physiology which we call neuroses. The terror of an explosion or the sudden threat to life involved in every collision, is now conceded to be an injury quite capable of setting up the physiological effects of fear in the individual and capable of exciting a neurosis. The fright of the moment through sympathetic stimulation, produces appropriate glandular responses; and the fear syndrome of palpitation, trembling,

weakness, merging into a sustained fear state or anxiety, results. Self-confidence gives way to insecurity, and gloomy forebodings create a desire for protection. In this crisis the individual finds himself surrounded by those same comforts, care, and kindnesses which shielded him in childhood, and unconsciously there is a temptation to regress, to become dependent. Once more the individual finds himself in the center of the stage surrounded by attentive relatives, a sympathetic wife. Into this setting come friends and neighbors, fellow workmen who recount tales of similar injuries, recall that safety devices were not provided, remind him of his right to compensation, warn him of complications,—and the traumatic neurosis is born.

The neurotic, then, is an individual burdened by heredity, weakened by faulty early training, conditioned by past experiences and unsolved problems—delicately balanced between success and failure, but leaning toward the latter, and to whom a railroad wreck, a bursting shell, an injury, is a life-saver. It supplies the occasion which is an excuse for showing the white flag of surrender, and at the same time gives it all an air of respectability. The soldier, torn between patriotism and duty and his instinctive fears, the workman struggling with his increasing responsibilities and diminished income, the housewife who is working out to add to the family purse, can now surrender to the unconscious wish to be freed from responsibility; and the result is a neurosis.

CLASSIFICATION AND SYMPTOMATOLOGY

Numerous classifications of the psychoneuroses and sub-classifications of what we call "traumatic neurosis" have appeared in the rather large literature that has accumulated in the past decade. It is doubtful if any one had improved on Freud's original grouping:

1. Neurasthenia.
2. Anxiety states.
3. Hysteria.
4. Obsessive—compulsive neurosis.

The first of these, neurasthenia, as it is now understood, describes that "irritable weakness" of the nervous system, the abnormal fatigability and exaggerated irritability which make the individual peculiarly susceptible to both physical and mental exhaustibility. The slightest effort seems to tire the victim, and he wakes up in the morning more exhausted than when he went to bed. Usually as the day progresses the neurasthenic feels better—the engine warms up as it were—and by night time he may feel fairly well.

The neurasthenic is usually hypochondriacal, or preoccupied with his own body or organs. It is the excessive interest in the automatic functions and the verbal expression of the sensations that makes the statement, "He enjoys ill health," seem apropos.

CASE REPORTS

Case I. Psychoneurosis—neurasthenic and hypochondriacal after injury.

Summary:—A constitutional neurotic with latent material for a neurosis consisting of chronic dyspepsia, dissatisfaction with his marital partner, business worries requiring him to do house to house selling although formerly accustomed to an office. A collision pinned him under the steering wheel, and he was terrified with the thought that he might burn. His head was cut by flying glass; he recalls the remark of a rescuer, "He's swimming in blood." He returned to work too soon and failed. Two years later he is still disabled, and will be as long as he can be paid to be sick.

Symptoms of Neurasthenia:—"I'm awfully nervous and the least little thing upsets me. When I get in a crowd I get all worked up and tremble and feel weak. If I read my eyes get blurry and I have a continuous pain in the back of my neck here at the base of my skull. It's a whole lot worse than it was a year ago. Sometimes a terrible fear hits me in the stomach and runs up my throat, and a lump comes there, and I can't swallow, and I feel like it will choke me. It feels like there's something pushing my temple in, and like there's a band across my forehead. Listen, Doctor, I'm getting pretty tired of not being able to enjoy myself. I don't care what happens to me, and one of these days—Why, when I sneeze I imagine my whole back will bust open," etc., etc.

The anxiety state is a neurosis with objective as well as subjective symptoms. The anxiety crisis is a real physiological storm. All of the fear responses are evident. The dilated pupils, dry mouth, rapid heart, and quickened respiration, the sensation of fear and trembling, with the terrifying thought, "This is the end." The acute attack soon subsides, but the chronic fear, the anxious expectation of the individual dreading another attack, continues. These individuals too have the general irritability, the gloomy forebodings, the hypochondriasis of the neurasthenic. In fact all of the neuroses are mixed.

Case II. Psychoneurosis—anxiety state after injury.

Summary:—A young woman whose injury consisted of poisoning by fumes. At the time, she had just secured a divorce, was working on a night shift which worried her, was compelled to leave her baby at home in the care of her aged parents. The ex-husband was threatening to kidnap the child and go West. From the night of the injury she regarded the attitude of the company doctor and factory superintendent as unfriendly. The peculiar thing about her collapse was that she suffered no apparent ill effects until after she had left the factory where she had seen several other girls collapse.

Symptoms of Anxiety State:—"I can't describe those paralyzed spells. My hands and feet get numb and draw, and my neck gets sore and pulls my bead back, and my heart races something awful. I don't faint, but I just feel—well—at first I'd get real panicky, but afterwards I could just get one and not mind it at all, only I get short of breath and my heart races and I feel like some-

thing terrible is going to happen, and break out in an awful sweat. I know it won't, but every time I try to go back to work they put me in the same room where I got poisoned, and I can't stand it," etc.

Hysteria has so many manifestations that it is impossible to describe them. The same mental characteristics found in the other three groups of the neuroses prevail here, but the distinguishing feature is the tendency to convert the nervous overflow into somatic signs and symptoms. The neurasthenic takes his out in an unending complaining and study of his dysfunctions. The anxiety patient suffers from physiological responses characteristic of the reaction to fear. The hysteric converts his mental worries and nervousness into something obvious, so that his illness speaks for itself. His illness usually takes the form of a motor or sensory paralysis, a peculiar gait or posture, or perhaps mental fugues or escapes in spells which he does not recall later on.

Case III. Psychoneurosis—conversion hysteria after injury.

Summary:—A young Italian temporarily employed at common labor although ambitious for a white collar job, received a minor injury to his shoulder. Two years later he claimed total disability, exhibited a flaccid paralysis in the right arm, offered to submit to amputation in order to relieve his pain. Four weeks later, after explanation, re-education and persuasion, he has regained the use of his arm and made a willing settlement of his claim about which there had been considerable trouble.

Symptoms of Conversion Hysteria:—"The same as right along, it is my shoulder. It is bother me with pain all the time and grabs me in that muscle. If I go to move my arm I ain't got no strength in it, and the only way I can move it is with my other hand. I can't use it; that's all the matter with me," etc.

Statement after treatment:—"When I was hurt the doctor say put bandage on for six weeks, but his assistant take off in three days. Then he took the bandage off and just put a small lamp on it. Then when I have pain in my shoulder he took my tonsils out and say I have a woman's disease, and I need treatment. I went to another doctor and he say my nerve is cut and I am paralyzed. That worries me so I went to a specialist and he said I had a mental condition, and that made me mad. One doctor gave me shots in the arm then and said I had arthritis. Then I went to a surgeon and he operated on my shoulder here, but it was no better when he got through. Now I know what is wrong, and I believe you because you explain and tell me the truth."

The victim of the obsessive compulsive neurosis seldom belongs to the traumatic group. The obsessive patient is usually over-scrupulous, hampered by doubts, has a tendency to fruitless speculation—frequently about himself. He has thoughts which he finds it difficult to repress, fear of saying a naughty word, fear of high places, fear that he will throw himself in front of a train, and these become so annoying that the individual fears he will lose his mind. These same people wonder if they have locked the door at night, and return to see, not once but twice. They wonder if they have not caused some one harm, and will go back to see if they did not crowd another car off the road at that dangerous turn. Worst of all is their feeling of unreality in which everything seems strange, and they declare they have no feeling, no memory, are losing their minds. Most people have some obsessive ideas, like the persistence of a tune which won't go away, or a compulsive idea which won't let them, "Step on a crack for fear it will break your mother's back."

DIAGNOSIS

It is impossible to consider here the signs and symptoms found in the neuroses which distinguish them from the organic diseases on the one hand and malingery on the other. It is of some importance to know that malingery is of rare occurrence, less than 1 per cent in the experience of most medical examiners.

Perhaps the best suggestion in regard to diagnosis is to place emphasis on the close questioning of the examinee as to every particular of the accident, recording his statement in his own words. A careful history of the onset and development of the symptoms he claims, will usually reveal the too obvious caution of the malingerer and the inconsistencies and innocent exaggerations of the hysteric.

It is not enough to "catch" a patient by trickery. Even the hysterical patient with a paralyzed arm may use it under strong suggestion. It is a part of his suggestibility that one has succeeded in demonstrating, and not his motive, which is conscious in the malingerer and unconscious in the hysteric.

The examination cannot be too thorough in hysteria. The examiner who is unbiased, who watches for the unusual, the bizarre, will see in the responses to the usual physical tests—the gait, the responses to sensory stimuli,—the signs of the neurotic. If the patient limps it is often helpful to direct him to walk backward, and the novelty of the order will often uncover the functional nature of a gait that looked spastic a moment before. The diagnosis of hysteria should, however, be reserved until every organic possibility known to the examiner has been ruled out. Hysteria should be thought of last, and not first.

TREATMENT

The therapeutics in the traumatic and non-traumatic neuroses is not the same. In the non-traumatic we do not have to consider an injury or the very important subject of compensation. The non-traumatic neurosis is not unlike a decompensated heart, and compensation and recovery occur when, under rest and proper management, explanation, persuasion, and a discussion af the conflict have been given. It should be recognized that it is a remission rather than a cure, for the

neurotic is always a neurotic although he need not necessarily have a return of his neurosis.

The most important treatment, as in other chronic and constitutional disorders, is preventive. The best early treatment is to be found in the understanding attitude of a doctor able to recognize the pre-neurotic state, who is gifted with ability to impart confidence, to lessen fright, and to dispel fear. This doctor will show interest and not sympathy. He will be thorough in his examination, but will avoid the suggestion that the injury is serious as far as possible. He will anticipate the worries of the patient and will provide counter suggestions against the fears planted by the patient's friends and relatives. He will promptly establish a hopeful attitude on the part of the patient.

The surgeon who deals with emergencies too often concerns himself with obtaining a pretty scar, and is inclined to forget or ignore that there has been a psychic wound, and that psychic scars are even more disabling and costly to both the injured man and the insurer than any ordinary physical injury. Too often it is the doctor himself who establishes the fears and doubts which produce the neurosis by talking about a broken spine, a fractured skull, and warning of dangerous complications in order to impress the patient and relatives with his own skill and service. The same time spent in a friendly discussion of the patient's problem and the giving of a little experienced advice and encouragement, would reflect more to his credit.

In the beginning of the neurosis as well as in long established cases, it is necessary to remember that we are dealing with a nervous individual whose mental illness consists of a group of false beliefs. Such an illness requires mental treatment. It is not enough to soothe with rubs or to impress with electric treatment. These may add to the patient's comfort but at the same time increase his emotional reaction by their repeated reminders of the injury he has sustained. Nor do surgery and the application of casts and braces bring about a cure. Such procedures do not help the neurosis; they only help to conceal it.

The cure of the neurosis, if we can use the term, consists in re-establishing the morale. The loss of this is the "decompensation" of the neurotic. To get well he must be made to "know himself," to recognize that in his case it is true that "as a man thinketh, so is he." First reassurance, then explanation when his confidence has been gained, persuasion to try again when the individual has become fortified against his weakness by repeated encouragement, and we have described the most practical form of psychotherapy, one that is available to every physician. In this process of re-education we must avoid impressing upon the sick man too strongly his own constitutional weakness, and take pains to see that he is not belittled or made to feel degraded and robbed of his self-respect. This is the fine art of treatment.

COMPENSATION

The subject of compensation in traumatic neurosis is important enough to demand a separate discussion. There can be no denial that recovery in traumatic neurosis is seldom obtained under any form of treatment while compensation continues. Even when the victim has been convinced by psychotherapy, he is not always cured. A man can learn all about flying an airplane, but lack the courage to take the plane into the air. It requires a normal, healthy personality to abandon compensation for the hard row of finding a job during the depression. With stronger hearts failing, is it any wonder that the same thing happens in our "weaker brother"?

With fears kept open by uncertainty of compensation, re-examinations and re-hearings, all of which call for the continued demonstration of the right to compensation, it is natural that appropriate emotional attitudes will develop. The neurotic patient becomes a specialist and knows every ache and pain in his whole anatomy. He needs them to confirm his own fears and desires, as well as his conviction of his right to compensation. In these efforts he finds ready support in the "crepe hanging" consultants who visit him as friends and neighbors.

The right of the neurotic to recover from disability resulting from his illness has been established. We have also come to recognize that poor psychic treatment by the doctor at the time of the injury and subsequently, can be quite as damaging as careless surgical handling of a fracture or hernia. The man with a susceptible nervous system is entitled to the same protection as the man who has fragile bones or a damaged heart. However, while the courts in this country refuse to recognize the neuropathic predisposition in measuring the effects of an injury, it does not seem fair to ignore entirely the reversible nature of the neurosis and the contributing factors and mental mechanisms which may prolong such a disability indefinitely.

We recognize that a neurosis is curable, but the neurotic tendencies are inherent. We should not forget that the patient does have a considerable control over his condition and that he is not the victim of an irrevocable defect such as a crippling fracture or the amputation of an extremity. It is unfair to apply the same compensation values to disabilities which are kept in existence to a large degree by the patient's own attitude and his acquired taste for lazy leisure, freedom from responsibility, and inherent weakness exaggerated by covetousness and self-pity.

More than a half century ago a neurologist, wise before his time, remarked that metalotherapy was the most effective cure for what we call

traumatic neurosis, and recommended gold in particular. This was before the day of weekly payments, unlimited periods of disability, and the hope of being declared a "permanent total." These tendencies in human nature cannot be ignored, and the problem they create from the standpoint of economic loss and human values is tremendous.

We need to consider and to discuss these problems, not only from the medical standpoint, but also from the standpoint of compensation. It is probable that the solution of the problem will be found to rest in the establishment of medical boards granted wide authority in the settlement of these cases. Perhaps such boards will find it necessary to classify these neuroses and to estimate arbitrarily the period of disability to which each individual is entitled according to the nature of the individual circumstances. If it is fair to establish the value of an eye or a leg, such a plan does not seem unreasonable.

Experience in certain European countries as well as in private insuring companies and medical examiners, has demonstrated the value of prompt settlement of claims without physical injury where the neurotic element is easily recognized. Without injustice to the injured individual, a lump settlement affects a cure in a large percentage of the cases. When one contemplates that of 2,500 cases of "shell shock" awaiting transportation to the United States when the armistice was signed, 2,100 were "cured" five days later, we can realize the tremendous effect of a psychic influence in the neurotic patient. In this group of patients which we have considered, neurosis after injury without structural basis, we need to recognize that the hope of indefinite or permanent compensation is like a focus of infection with its continuous toxic effect, and poisons the mind of the innocent victim, robs him of his independence and self-respect and perpetuates a mental illness. It is an element which must be considered in the solution of this problem.

350 E. STATE STREET.

DISCUSSION

H. H. DRYSDALE, M.D., Cleveland: Doctor Harding is to be commended for his sane and rational appraisal of what is always a complex problem. It is true, as he avers, that during the past five hectic years our courts have been clogged with damage suits under the guise of traumatic nervousness and too many physicians have testified that such conditions were not only wholly attributable to trauma but frequently incurable. In 1927 we endeavored to follow up 117 cases of alleged post-traumatic neurosis and found that 99 had returned to gainful work. The remaining 18 could not be found but sufficient information was secured to warrant the assumption that at least nine of them had been restored to health. Of course certain people in times of financial duress, and their number is legion nowadays, will go to any extreme to obtain funds. An injury, irrespective of the degree of physical violence, is one way of meeting this need. When no objective somatic manifestations prevail a claim on the ground of functional nervousness is invariably the rule. I might also add in this connection that in recent times, I have repeatedly been called to the phone to receive a message, to the following effect: "Doctor, my mother (or some other member of the family) was injured in an automobile collision and while she sustained no fracture, cuts or bruises, was severely shocked. We understand the insurance company is investigating the claim and if they come to you will you be good enough to overlook the fact that you treated her for a nervous disorder a few months ago?" Naturally a physician cannot retain his self-respect by condoning such methods. Moreover the average juryman and jurywoman have become medically-minded and are now more capable of intelligently appraising claims of this character. It is therefore not surprising that the day for large verdicts in cases of functional nervousness has passed.

To the normally constituted individual work is an impelling joy and satisfaction. When subjected to injury such a person will chafe under prolonged hospitalization, do everything possible to accelerate his recovery and return to his place in industry. But the unstable workman when traumatized abandons himself to a state of physical and mental lethargy. To him, a casualty, no matter how trivial, provides a period of rest and release from labor which he is unwilling to relinquish until satisfactorily compensated. He promptly consults an attorney who refers him to a physician known for his sympathetic interpretation of subjective syndromes. From then on the claimant is no longer a patient striving for his health but a client of the legal profesion concerned only with the hope of winning a substantial verdict.

The problem therefore is fundamentally one of constitutional instability, or in other words we are dealing, in a large majority of instances, with traumatized neurotics. Their symptomotology, as Dr. Harding well said, differs in no wise from the general run of psychoneurotics and a correct diagnosis oftentimes is none other than an appraisal of the individuals' integrity.

Dr. Harding also stressed, as many of this section have heretofore stressed, the importance of surrounding all postraumatic patients with an atmosphere of renewed courage and hopefulness from the very onset. All of them are profoundly impressionable especially if what they hear sounds disheartening or unfavorable. Here the industrial surgeon, above all others, has an opportunity for real constructive service and I am happy to say from personal experience, that he, in increasing numbers, has sensed this responsibility and is applying modern prophylatic measures most efficiently. Of course when confronted by a malicious individual, his efforts no matter how intelligently and diplomatically administered will prove futile and every industry has had this sort of claimant to deal with.

Ordinarily when so-called post-traumatic patients cross my path their condition has assumed a tenacious or rebellious form. Like certain delusions, their complaints are now a fixture with them, to remain until released by adequate compensation. But after a searching physical investigation plus ample psychological observation has been made and their symptoms do not ring true—are inconsistent—or when the individual wilfully attempts to deceive or exaggerate his condition, he or his representative is frankly informed that the alleged complaints are not sufficient to con-

stitute a disability and he should divert his thoughts from self by engaging at once in some gainful and congenial pursuits, as work is his cure. When this position is taken it is surprising how few reach the court-room as the claimant is utterly helpless without medical testimony to maintain his claim.

On the other hand I am willing to go a long way in behalf of those individuals who develop a geunine neurosis as a complication of trauma and while the disability is usually temporary they are entitled to every possible consideration. Fortunately they constitute but a small minority.

During recent years several reputable neurologists have taken the position that certain cases of post-traumatic neurosis are explainable on the basis of organic changes in the brain that can be visualized by encephalography. They readily admit, however, that what constitutes a normal encephalogram has not been finally established, but they contend that physiologic variants of the contour of the ventricles and the subarachnoid space are rare, and that given a good technic, certain well known changes on the roentgenogram indubitably point to the existence of some degree of previous or present intracranial damage. Another school of neurologic thought is strongly opposed to this assumption and emphasizes the fact that the neuroses following trauma to the head do not differ from those developing after injury to other parts of the body, in which injury to the central nervous system cannot be in question.

In the absence of normal controls and until cerebral pneumographic interpretation reaches a higher degree of efficiency we should hesitate to classify post-traumatic neuroses organic. A diagnosis of this sort implies a dark prognosis and if not sound is eminently unjust to the patient and most unfair to the defendant.

JOS. L. FETTERMAN, M.D., Cleveland: Dr. Harding is to be complimented for his practical and timely presentation. Its delineation of the neurotic personality is both vivid and psychologically sound.

His statement that the term "traumatic neurosis" conveys an impression which does not conform to all the physical and psychologic facts, is in line with a suggestion I made in June that the term be replaced by the more correct phase of "Neuroses Associated with Trauma." Such a title is comprehensive and does not carry with it the implication of cause and effect which is contained in the popular, though I believe incorrect phrase "Traumatic Neurosis."

Experience has taught us that within the group of neuroses associated with trauma, there are several subdivisions, correlated because the symptoms are those of a neurosis but differing widely as to motivating cause. On the principle of dominating causative factor, I had proposed a classification somewhat as follows:

Type I, Injury—due to physical damage from brain and cord trauma.

Type II, Industrial—due to human difficulties or physical dangers at work.

Type III, Indemnity—due to a drive for compensation.

Type IV, Inherent—due to pre-existing or potential neurosis.

Of course, in addition to these four groups, there are many transition forms as well as combinations.

Dr. Harding stressing the psychologic nature of the neuroses has prudently omitted the cases of head injury which fall in group one of the above classification, and which are frequently due to physical, organic changes.

As brought out by the essayist, the problem of compensation is most difficult to handle. This classification facilitates to some degree, the evaluation of the money reward. Patients in group one are entitled to compensation. Those in group three and four should receive little or no compensation. Patients grouped in type two require work adjustment.

OCCUPATIONAL DISEASE REPORT FOR 1934 AND SUMMARY FOR PAST YEARS

By EMERY R. HAYHURST, M.D.,*

COLUMBUS, OHIO

INTRODUCTION

UNDER Section 1243-1, General Code of Ohio, and Regulation 2 passed by the Public Health Council on February 27, 1920, "Every physician in this state attending on or called in to visit a patient whom he believes to be suffering from * * * * any disease or disability contracted as a result of the nature of the person's employment" shall report same to the State Director of Health on special forms provided for that purpose. By sub-section 3, such reports cannot be used in medicolegal relations regarding the cases as reported, but by subsection 4 are referred to the Chief State Factory Inspector.

Under this law and regulation, a total of 1,556 cases (exclusive of 49 "incompletes") were reported in 1934 as compared with 1,258 in 1933, and with 1,382 in 1929—the previous highest year. The increase represents 23.7 per cent over 1933 and 12.6 per cent over 1929.

The causes for the increase, which, it will be noted from Table I, began with 1933, have not been investigated, but are probably due to the employment of more persons in certain hazardous lines, the return to work of persons unaccustomed to same, more interest in the possibility of compensation and payment of medical fees, and the fact that 236 physicians, who had sent in the majority of reports since January 1, 1927, were circularized with a copy of the 1933 Annual Report, sent to them in May, 1934. The increase

* Consultant, Division of Hygiene, Bureau of Occupational Diseases, State Department of Health.

TABLE I. SUMMARY OF OCCUPATIONAL DISEASES REPORTED IN OHIO, 1928-1934, INCLUSIVE, BY COMPENSABILITY

	1928	1929	1930	1931	1932	1933	1934	Total
Compensable	1,127	1,317	1,259	1,217	1,069	1,129	1,415[1]	8,533
Non-Compensable:								
Agents	23	32	29	53	57	104	104[2]	402
Afflictions	25	33	30	24	33	25	37[3]	207
Total	1,175	1,382	1,318	1,294	1,159	1,258	1,556	9,142

1. 41 incomplete (semi-official) reports not included, composed of dermatitis 32, tenosynovitis 3, bursitis 2, lead 2, carbon dioxide 1, chrome 1.
2. 4 incomplete (semi-official) reports not included, composed of dust 3, chemical poisoning 1.
3. 4 incomplete (semi-official) reports not included, composed of tuberculosis 2, asthma 1, asthenopia 1.

was not due to the addition of new diseases to the list of compensable diseases as none were added by the last Legislature.

Of the 1,556 cases here reported, 290 or 18.6 per cent occurred among females.

COMPENSABLE CASES

As is usual, the reports of compensable cases, 1,415, far out-numbered the non-compensable, 141.

Of the 22 afflictions compensable under Section 1465-68a, only 13 registered reports in 1934. Of these, dermatitis (variously specified) comprised 913; tenosynovitis (hand), 228; lead poisoning (and lead absorption), 162; chromium ulcerations (nasal or skin), 43; prepatellar bursitis, 27; benzol (with its derivatives), 10; petroleum (with its derivatives), 10; brass or zinc, 8; sulphur dioxide, 7; arsenic, 3; compressed air illness, 2; carbon bisulphide, 1; carbon dioxide, 1. Table II will show at a glance which compensable afflictions were active and which were of no material concern.

Dermatitis. Dermatitis, 913 cases (58.7 per cent of the total for 1934), continued as the leading factor in the compensable group. Of this number, 194 (21.2 per cent) were females. The causative agents of these 913 cases were: Oils and cutting compounds, 131; alkalies and cleaners, 83; gasoline and other petroleum products, 49; paints, enamels, etc., 48; rubber products, 45; bakelite, 44; plants, woods, etc., 44; lime and Portland cement, 42; dyes and dyed goods, 40; plating solutions, 34; chromium compounds, 25; hides, leather and furs, 25; textiles, 23; others (11 or less in each group), 280. Of the 913 dermatitis cases, 194 (21.2 per cent) occurred in *females* as follows: Alkalies and cleaners, 21; dyes and dyed goods, 19; oils and cutting compounds, 18; rubber products, 18; bakelite, 16; textiles, 15; paints, enamels, etc., 10; plants, woods, etc., 10; hides, leather and furs, 9; gasoline, etc., 7; plating solutions, 5; others (less than 5 each), 46.

Lead Cases. The total of 162 lead cases were distributed as follows: Storage batteries, 85; paints, dry colors and painting, 26; lead manufacture and recovery, 7; caskets and vaults, 6; sanitary ware, 6; pottery, 5; brass and bronze, 4; automobiles, 3; rubber, 3; printing and publishing, 2; others (2 or less, each), 15. Of the lead cases, 3 were *females*,—one engaged at filing in the manufacture of plastics, one as a brass assembler, and one as a solderer in a carbon company.

Vital Statistics have not yet been completed for the year 1934, but the number of *deaths*, either accredited to *lead poisoning* or in which lead poisoning was specified as a contributing cause, was as follows for the respective 6 preceding years (1928-33 inclusive): 10, 17, 2, 11, 7 and 12,—a total of 59 deaths associated with lead poisoning.

NON-COMPENSABLE CASES

(a) Year 1934. Interest centers chiefly in the non-compensable cases. These are subdivided into (1) causative *agents* indicated or specified, and (2) *afflictions* specified, but causative agents not known or at least not indicated in the reports (or follow-up inquiries).

There were reported 104 in the *agent* group, and 37 in the *afflicted* group. Space does not permit the inclusion of a long table covering the non-compensable occupational diseases reported, but they may be summarized as follows:

Causative Agents Indicated or Specified: Of the total of 104 in this group, 54 were from the inhalation of *dust* divided as follows: Silicosis, 42, silico-anthracosis 5, silicatosis 1, asbestosis 0, others 6; 12 were due to *carbon tetrachloride* (10 of which, all females, were mild cases occurring in a rubber plant, while trying out a new procedure); carbon monoxide (repeated exposures) 5, chromium (constitutional effects) 4, and the rest due to 22 other causes.

Causative Agents Not Indicated: The total of 37 cases under this heading were divided as follows: Tuberculosis, 14; tenosynovitis (other than hand), 3; asthma, 2; bursitis (other than prepatellar), 2; bronchitis, 2; conjunctivitis, 2; heart disease, 2; and one each of the following—arthritis, comedones, kidney colic, myasthenia, nephritis, neuritis, phlebitis, scarlet fever, typhoid fever, ulnar neurosis.

(b) Years 1928-1934, Inclusive: From Table I, it will be noted that for this seven-year period

TABLE II. SUMMARY OF COMPENSABLE OCCUPATIONAL DISEASES REPORTED 1928-1934, INCLUSIVE

Schedule Number and Name	1928	1929	1930	1931	1932	1933	1934	Total
1. Anthrax	.....	.....	.....	.....	.....	.....	.....	.....
2. Glanders	.....	.....	.....	.....	.....	.....	.....	.....
3. Lead poisoning	180	183	134	114	148	134	162	1,055
4. Mercury poisoning	.....	.....	.....	.....	.....	.....	.....	.....
5. Phosphorus poisoning	.....	.....	.....	.....	.....	1	.....	1
6. Arsenic poisoning	.....	2	1	2	3	1	3	12
7. Benzol poisoning (and nitro-or amido-derivatives)	11	11	3	6	9	3	10	53
8. Volatile petroleum products poisoning (gasoline, benzine, naphtha, etc.)	3	4	2	6	5	9	10	39
9. Carbon bisulphide poisoning	1	1	.....	18	2	1	1	24
10. Wood alcohol poisoning	1	.....	.....	1	.....	.....	.....	2
11. Dermatitis*	894	985	884	833	621	726	913	5,855
12. Epithelioma (skin or eyes) due to carbon, pitch, tar or tarry compounds	3	2	1	5	1	1	.....	13
13. Compressed air illness	16	62	59	5	20	3	2	167
14. Carbon dioxide poisoning	.....	.....	.....	.....	.....	1	1	2
15. Brass or zinc poisoning	7	5	2	10	2	12	8	46
16. Manganese dioxide poisoning[1]	.....	.....	.....	.....	.....	.....	.....	.....
17. Radium poisoning[1]	.....	.....	.....	.....	.....	.....	.....	.....
18. (a) Tenosynovitis[1] (hand)	.....**	37	130	166	149	191	228	901
(b) Prepatellar bursitis[1]	.....**	13	23	29	23	19	27	134
19. Chrome ulceration (nasal and skin)[2]	6	10	20	16	79	20	43	194
20. Potassium cyanide poisoning[2]	3	2	.....	1	3	5	.....	14
21. Sulphur dioxide poisoning[2]	2	.....	.....	5	4	2	7	20
Total	1,127	1,317	1,259	1,217	1,069	1,129	1,415	8,533

*Specified as "Infection or inflammation of the skin on contact surfaces due to oils, cutting compounds or lubricants, dust, liquids, fumes, gases or vapors".

** Statistics not kept on Tenosynovitis and Bursitis in 1928. Both of these afflictions had been compensated as "accidental" injuries previous to July 1, 1929.

(1) Added to compensable list July 31, 1929, by Legislative Act, 88th General Assembly.

(2) Added to compensable list July 9, 1931, by Legislative Act, 89th General Assembly.

there was a total of 609 *non-compensable* cases, of which 402 were due to indicated or specified *agents*, and 207 to *afflictions* whose causative agents were either not indicated or were not known sufficiently well to be evaluated.

Under *Agents*, the 402 cases were divided as follows: Dust, 182; cyanides (other than potassium, which is already compensable), 24; carbon monoxide (repeated exposures), 22; lacquer and similar finishes (constitutional poisoning), 13; turpentine, 9; undulant fever (abattoirs, dairying, etc.), 7; tularemia (handling rabbits, etc.), 6; others (due to a long list of miscellaneous causative agents, each with 5 or less cases), 139.

Dusts. The 182 afflictions due to dust inhalation were reported in the 7 respective years (1928-34) as follows: 13, 15, 12, 19, 22, 47, 54. In the last few years many of the dust cases have had their *X*-ray chest films sent to the Department for evaluation and very complete records are had upon them. As a rule they represent a totally and permanently disabled group. Most of these cases were reported by the various state tuberculosis sanatoriums, but some came from hospitals and private practitioners. In addition, we hear rumors of many more "dust cases", but they have not been reported upon official forms. This prompts us to say, at this point, that about 35 per cent of all occupational disease reports received by the State Director of Health are first notified from the Industrial Commission which necessitates the forwarding of a special form letter and report blanks to the physicians who sent in claims for compensation and medical fees in advance of reporting.

Obviously, this failure to report is not complying with the reporting statute and is hindering the factory inspection division, as well as the collection of information upon which to base an estimate of the real prevalence of any occupational disease, including those which the legislature might see fit to add to the compensation schedule.

In addition to the 182 cases duly reported for dust inhalation during the seven-year period under discussion, there were also reported 217 *afflictions* with unnamed causative agents (many of which were associated with dust inhalation): Pulmonary tuberculosis, 64; bronchitis, 47; asthma, 11; upper respiratory irritation, 8; also, conjunctivitis, 10; neuritis, 18; arthritis, 7; other cases, 52.

PORTAL OF ENTRY

Of the 1,556 occupational diseases reported in 1934, 327 occurred chiefly through inhaling the substance, 933 by way of the skin, 228 through strain, 27 through friction, and 41 through other and non-specified means.

ACUTE MISHAPS

Acute poisonings, sudden injuries from splashing of chemicals, asphyxiations, injuries from direct blows to tendons and bursae, sudden strain, etc., are not included in any of these figures since we do not regard them as coming properly under the definition of "disease". They are also covered by compensation as "accidental" injuries.

NUMBER OF PHYSICIANS AND EMPLOYERS

According to the A.M.A. Directory (1934) there were 8,769 physicians registered in Ohio in 1934. Of these, 626 (7.2 per cent) sent in 1,422 of the occupational disease reports (the balance being reports by two or more physicians, physicians residing outside of Ohio, incomplete reports, etc.) Of these reporting physicians, the leader, a plant physician, reported 108 cases; the second highest, a company of industrial physicians, 59; the third, another plant physician, 48, the fourth, a clinic physician, 24; and the balance 20 or less.

In the past seven years, a total of 9,142 occupational diseases were reported by approximately *2,500* different physicians, and were employed by approximately *3,350* different employers.

ANALYSIS, 1913-1934

From the date of the receipt of the first report, May 15, 1913, a total of 17,443 occupational diseases was reported to the end of 1934. During the first 8 years, before occupational diseases became compensable, only 2,575, or an average of 322 cases per year were reported. Since compensation began (August 4, 1921), 14,771 have been reported, or an average of 1,100 per year, an increase of 341.6 per cent over the non-compensatory period.

— OSMJ —

Ohio Physicians Urged to Cooperate In Promoting Immunization By Head of Child Health Day Activities

Ohio physicians and the county medical societies and academies of medicine in the state are urged to cooperate in the "Immunize Now—Stamp Out Diphtheria" campaign to be carried out in Ohio during the ensuing year as a part of the National Child Health Day celebration, held annually on May 1.

Activties in Ohio are headed by Dr. A. L. Van Horn, chief of the Bureau of Child Hygiene, State Department of Health, who in the following communication requests the cooperation of the medical profession of Ohio and points out the importance of greater activity in immunization in this state:

"'It is within the power of man to rid himself of every aprasitic disease' "—so prophesied Louis Pasteur 75 years ago. At that time such a prophesy must have sounded almost ridiculous but today we well appreciate the truth of such a statement. Medical science in the past 75 years has provided means for wiping out the majority of communicable diseases and consequently has nearly doubled man's life expectancy. Perhaps the most notable accomplishments are reflected in the figures in Table 1, accompanying this communication.

TABLE 1

DEATH RATE * FOR CAUSES OF DEATH IN OHIO

Year	Smallpox	Diphtheria	Typhoid Fever	Tuberculosis
1910	0.29	9.9	27.9	150.8
1915	0.16	13.2	14.1	131.0
1920	0.31	11.0	7.5	102.1
1925	0.74	6.2	5.1	76.1
1930	0.21	2.4	3.5	63.4
1934	0.0	2.8	1.6	49.6

* per 100,000 population.

"That our task is far from being completed is evidenced by the fact that nearly 200 deaths occur every year in Ohio from diphtheria. Such a mortality from diphtheria should never exist in the State of Ohio. Perhaps in the case of no other disease has such outstanding progress been made with preventive measures and still we have deaths from diphtheria. One important phase of this problem which is not readily appreciated by many physicians is the relatively large number of deaths which occur among children of preschool age. In Table 2 is shown the number of deaths in Ohio from diphtheria in various age groups during the past five years.

TABLE 2

DEATHS FROM DIPHTHERIA

Year	Total No. of deaths	at different ages 0.5 yrs.	5-9 yrs.	10-14 yrs.	15 yrs and over
1929	225	112	64	18	31
1930	160	87	46	10	23
1931	190	89	52	13	36
1932	223	106	74	13	30
1933	164	88	53	15	8

"A glance at this table reveals that approximately 50 per cent of all deaths from diphtheria occur in the preschool group. The common custom of immunizing just prior to entering school is not sufficient. We are neglecting the young child when he is most susceptible. What we need is a shift in our efforts from the school child to the infant and thus insure every child of adequate protection against diphtheria.

"May 1 is celebrated annually as National Child Health Day and the slogan for this year's activities is 'Immunize Now—Stamp Out Diphtheria". Every effort will be made through various agencies by means of talks, plays, movies, posters, pamphlets, etc., to urge parents to have their infants and children immunized.

"The entire success of such a program depends entirely upon the interest and cooperation of the physicians in every community in Ohio. We have the means of eradicating diphtheria from this state, it is up to us to see that every child in Ohio is offered protection against it. We would urge that each county medical society adopt plans for cooperating in and promoting immunization campaigns in their respective counties."

PLANS FOR 1935 ANNUAL MEETING, MEDICAL PROBLEMS OF POOR RELIEF, LEGISLATION AND OTHER IMPORTANT MATTERS ACTED ON AT MARCH MEETING OF THE COUNCIL

MINUTES

THE Council of the Ohio State Medical Association met in the headquarters office, 1005 Hartman Theatre Building, Columbus, Sunday, March 10, 1935.

The officers, Councilors, committee chairmen and others present were: President, Dr. Caldwell; President-elect, Dr. Hendershott; Treasurer, Dr. Beer; Past President, Dr. Cummer; Councilors, Drs. Smith, Huston, Klotz, Jenkins, Davidson, Kirkland, Brush and Seiler; Dr. Upham, chairman, Drs. Alcorn and Platter, members, Policy Committee; Dr. Bigelow, chairman, Medical Economics Committee; Dr. Rogers, chairman, Publication Committee; Dr. DeCrow, representing Dr. Hartung, State Director of Health; Executive Secretary Martin, and Assistant Executive Secretary Nelson.

The minutes of the Council meeting held on December 16, 1934 (pages 37 to 42, inclusive, of the January, 1935, issue of *The Journal*) were read, and on *motion* by Dr. Huston, seconded by Dr. Jenkins and *carried*, were *approved*.

ANNOUNCEMENT OF RESIGNATION

At the outset of the meeting, Dr. Caldwell, the President, called attention to the resignation by Executive Secretary Don K. Martin communicated by mail to the members of Council, effective March 15, to accept the position of manager of the Ohio Manufacturers' Association. On *motion* by Dr. Huston, seconded by Dr. Brush and *carried*, this resignation was *accepted* with regret.

REPORT ON MEDICAL RELIEF SITUATION

Attention was called to the article published on page 219 of the March *Journal*. A report was submitted on correspondence and conferences with the new Executive Director of the State Relief Commission, Mr. W. A. Walls, the latest conference having been held on Friday, March 8, at which time there was a detailed discussion of a written communication and brief previously submitted to Mr. Walls under date of February 25, in which the Policy Committee of the State Medical Association submitted for discussion the following general points:

(a) Organization of medical advisory committees in each county with the cooperation and approval of the county medical society, as contemplated under Federal Rules and Regulations No. 7, for the purpose of creating better mutual understanding and cooperation by the medical profession and relief administration.

(b) Provision for furnishing medical organization, for publication in *The Journal* and otherwise, detailed official information and all regulations affecting medical care to the needy.

(c) Elimination of the present arrangement whereby a maximum is allotted to each local relief administration for medical care in the amount of $1.00 per family per month on relief. Provision for more adequate funds and flexible arrangements to meet medical needs in epidemics or where there is an unusual amount of illness.

(d) Definite instructions to case workers or others attached to relief administration *not* to diagnose illness, prescribe or dispense medicine, this being exclusively the legal function of physicians.

(e) Consideration of possible future provision and more adequate arrangement through the state in the handling of indigent cases requiring hospitalization.

(f) Consideration of anticipated problems with the revival of the proposed work relief projects or in connection with prospective changes for the decentralization of relief to the needy.

(g) Revision and simplification of records and procedure on medical service to eliminate unnecessary red-tape and formality placed on physicians in securing signatures of patients on relief supply orders.

The State Relief Director, Mr. Walls, and heads of divisions who attended the latest conference with him, showed an understanding of and a sympathetic attitude toward the problems of medical care and to the presentation submitted by the State Medical Association, and gave assurance that plans would be made to meet the requests submitted by the medical profession in practically all the general items referred to, including provision for medical advisory committees and elimination, if possible, of the inflexible $1.00 per family per month arrangement and the pro-rating procedure, if sufficient funds could be secured to insure reasonable or adequate compensation for medical care.

Mr. Walls pointed out present difficulties of finance and the uncertainty of the situation in relation to federal appropriations, as well as the individual status of the State Relief Commission itself pending re-enactment of emergency legis-

lation to continue the functions of the Commission.

Encouragement was given to further conferences and negotiations with the medical profession in an effort to solve misunderstandings and difficulties.

Several Councilors reported on developments in the relief situation in their districts. These reports seemed to indicate some improvement in the situation over previous months.

Dr. Caldwell and Dr. Platter reported on a conference held on the preceding day with a committee of the State Nurses' Association on educational and professional relations. They related the request of the nurses for cooperation and their insistence on re-establishment of a nurse division in the State Department of Health. They also discussed the dissatisfaction of the nurses in the relief situation and the policy whereby social workers—not nurses—are being employed as nurses, and the short-time courses for so-called "practical" nurses under the auspices of the FERA.

On *motion* by Dr. Huston, seconded by Dr. Davidson and *carried*, the Council expressed and reaffirmed the policy to the effect that whenever legitimate nursing services are required as a part of the relief program, that registered nurses from among those now unemployed should be employed for such services.

1935 ANNUAL MEETING

Dr. Smith, chairman of the Council Committee on Arrangements and the Council Program Committee, reported on the conflict in dates previously set for the Annual Meeting, and under authority previously granted by the Council to his committee, announced that the forthcoming Annual Meeting in Cincinnati would be held at the Netherland Plaza Hotel, Wednesday, Thursday and Friday, October 2, 3 and 4.

A report was also submitted by Dr. Smith on the proposed schedule for the Annual Meeting, including Section and General Sessions.

On *motion* by Dr. Cummer, seconded by Dr. Seiler and *carried*, the Council *approved* the schedule and general program set-up as recommended by Dr. Smith and his committee.

Dr. Smith also submitted for the consideration of the Council problems in connection with scientific exhibits, expenses incurred in this feature of the meeting and other details. Several members of Council emphasized the educational value of scientific exhibits and advocated an expansion of this feature of the program.

Upon *motion* by Dr. Davidson, seconded by Dr. Seiler and *carried*, Dr. Smith and his committee were authorized to work out details of the scientific exhibit, including necessary expenditures, equipment, facilities, etc.

Dr. Klotz submitted to the Council a resolution adopted by the Northwestern Ohio Medical Association, requesting that consideration be given to holding future Annual Meetings of the Ohio State Association in the Spring preceding the annual meeting of the American Medical Association.

Attention was called to the fact that the House of Delegates had officially set the 1935 Annual Meeting for the Fall.

On *motion* by Dr. Cummer, seconded by Dr. Davidson and *carried*, the resolution was placed on file with the idea that this situation be brought to the attention of the officers of the Northwestern Ohio Medical Association and attention called to the fact that the House of Delegates at the coming Annual Meeting under the Constitution would determine when and where the 1936 Annual Meeting will be held.

Dr. Rogers, chairman of the Publication Committee, suggested the advisability of a joint conference of the Council Program Committee with the Publication Committee in advance of the Annual Meeting and in advance of official action on the program, to eliminate possible future misunderstandings on the rejection for publication of papers scheduled and presented on the Annual Meeting program. Dr. Smith announced that he would be glad to arrange such a joint conference.

PROBLEMS OF SOCIAL MEDICINE

Dr. Upham reported at some length on the recent special session of the House of Delegates of the American Medical Association held on February 15, 1935, in Chicago, and called attention to the official action taken at that meeting as published on pages 212 and 213 of the March issue of the *Ohio State Medical Journal*.

A report was also submitted by Dr. Upham, Dr. Brush, Dr. Hendershott and Dr. Platter, who were members of a special committee of the Ohio Chamber of Commerce on the socialization of medicine. A report formulated by that committee and later approved by the Board of Directors of the Ohio Chamber of Commerce was read for the information of Council and there were expressions of general approval of the policy and data recorded in that report.

On *motion* by Dr. Brush, seconded by Dr. Jenkins and *carried*, Dr. Upham, as chairman of the Policy Committee, was authorized to communicate with the Ohio Chamber of Commerce in relation to this report along the lines of the discussion by the Council.

Recent developments in Washington in relation to the program of the federal administration and prospective legislation for social security and social insurance were discussed in connection with governmental policies generally and as having a bearing on state legislation.

PROBLEMS OF LEGISLATION

The Policy Committee, through Dr. Upham, chairman, submitted for the information and dis-

cussion of the Council a report on the mass of legislation pending in the Ohio General Assembly affecting medical practice and public health. A special supplement to the docket for the Council meeting contained a brief analysis of over 100 bills in the field of workmen's compensation, public health, social insurance, old age pensions, unemployment, poor relief, hospitals and hospitalization, cult and medical proposals; bills pending in relation to medical practice, medical education, legal rights of physicians, etc.; numerous tax proposals, automobiles, drivers' license, financial responsibility for automobile drivers; numerous bills on reorganization of county government, and a number of miscellaneous bills of at least incidental interest to and effect on the medical profession.

Attention was called to the necessity of more aggressive and concerted activity on the part of the legislative committeemen, and in this connection emphasis was placed on the responsibility of Councilors to stimulate such organization activity in their respective districts.

Attention was called to the report of the Governor's Investigating Committee on Workmen's Compensation starting on page 144 of the February 1 issue of *The Journal*.

A report was also submitted to the Council on conferences and the development of opposition to legislation previously agreed upon by the Ohio Hospital Association and the State Medical Association for the medical and hospital care of the needy sick, and enlarged functions of local health departments. Attention was called to the policy officially adopted by the Council at its last meeting on recommendation of the Policy Committee (pages 37 and 38 of the January, 1935, issue of *The Journal*). Several Councilors expressed their disappointment that such legislation had not been introduced, and attention was called to the necessity of following closely developments on reorganizatiton of county government and the provisions for relief of the needy to include adequate provision for medical care.

Attention was called to the present survey of state departments by a voluntary committee of business men headed by Col. Sherrill of Cincinnati and including as members Dr. D. B. Lowe of Akron and Dr. J. A. Doull of Cleveland. It was reported that this survey committee would undoubtedly refer to appropriate committees of the Ohio State Medical Association questions in connection with medical and health functions of government.

SALES TAX REGULATION

A report was submitted on the latest revised regulations by the State Tax Commission relative to the sales tax as it affects physicians, and special attention was called to the article starting on page 209 of the March 1 issue of *The Journal*. There was a discussion on the possibility of having the regulation modified as it affects oculists who dispense glasses, there being general agreement that as long as physicians did not actually engage in the commercial business of selling tangible articles, that they should not be considered "vendors" and tax collectors when they dispense eye glasses and other materials directly in connection with professional service and for which no separate charge is made.

ADMINISTRATIVE AND EXECUTIVE MATTERS

At this point the Council went into executive session. By invitation, Drs. Alcorn, Bigelow, Platter and Upham were present.

In connection with the resignation of Executive Secretary Martin to take the position of manager of the Ohio Manufacturers' Association, the Policy Committee submitted the following resolution:

In view of the fact that Don K. Martin, after sixteen years of devoted and efficient service as Executive and Counsel, has tendered his resignation,

Be It Resolved by the Council and Officers of the Ohio State Medical Association, that they tender to Don K. Martin their sincere regret at this severance of his connection with this organization, and hereby express to him their deep appreciation of his tireless energy, his wise counsel, and his devoted and efficient service.

With an unusual insight into the problems of medical practice and its responsibilities to the public, with loyalty to the ideals of professional service, and ever ready to defend the medical profession from the encroachment of non-medical and unprofessional practices, he has given a splendid service to organized medicine and to the health and welfare of the public of this state.

And, Be It Further Resolved that we express to him our heartiest best wishes for his success in the new field he is entering and that we will ever remember him with the most kind and the most pleasant memories.

On *motion* by Dr. Upham, seconded by Dr. Huston and *carried*, the foregoing resolution was unanimously *adopted* and signed by each officer, Councilor and committee member present at this meeting.

Dr. Cummer offered a resolution expressive of Council's feeling materially toward Mr. Martin: "Because his services will be required and used in partially completed activities, be it resolved that Mr. Martin's salary be continued until April 15, 1935."

On motion by Dr. Cummer, seconded by Dr. Seiler and *carried*, this second resolution was unanimously *adopted*.

Dr. Upham then discussed medical organization, the relations of the membership to the executive office, the necessity for the membership taking a more active part in the work of their organization, the character of *The Journal* and a consideration of an enlarged field of activities.

Dr. Seiler voiced approval of Dr. Upham's remarks.

Dr. Hendershott urged Dr. Upham to reconsider retiring from the chairmanship of the Policy Committee, and upon unanimous request he agreed to continue.

On *motion* by Dr. Cummer, seconded by Dr. Davidson and unanimously *carried*, President Caldwell appointed a committee of five to determine how to best extend the usefulness of the organization to its membership, the survey to include field activities and headquarters personnel and the expenses to be paid by the Association. The personnel of such survey committee is as follows:

DR. J. H. J. UPHAM, *Chairman.*
DR. C. L. CUMMER.
DR. ALBERT FREIBERG,
DR. R. R. HENDERSHOTT,
DR. H. M. PLATTER,

Consideration of more frequent Council meetings was urged by Dr. Seiler and was discussed and supported by Dr. Cummer and others.

On *motion* by Dr. Cummer, seconded by Dr. Seiler and unanimously carried, the share of stock in the Columbus Athletic Club held by Mr. Martin for the Ohio State Medical Association was donated to him for his use in continuing a personal membership in that club.

At this point Mr. Martin was invited into the meeting, and was apprised of Council's actions by President Caldwell. Mr. Martin expressed his appreciation and assured Council of his friendship, loyalty and cooperation to the fullest extent.

Upon *motion* by Dr. Huston, seconded by Dr. Cummer and *carried*, Assistant Executive Secretary Nelson was named Acting Executive Secretary at a salary of $400.00 per month. It was also agreed that the expense account of the Executive Secretary be at his disposal.

After discussion by Dr. Huston, Dr. Davidson, Dr. Smith and Dr. Seiler regarding office personnel, on *motion* by Dr. Smith, seconded by Dr. Klotz and *carried*, the special survey committee appointed by President Caldwell was empowered to make such temporary arrangements as necessary to carry on the work of the Association.

At this point the executive session ended and the regular session resumed.

MISCELLANEOUS

Dr. Huston submitted for the information of the Council recent correspondence with the Montgomery County Medical Society and the State Department of Health in relation to a proposed change in the quarantine period of scarlet fever. He called attention to the fact that assurance had been given that the Public Health Council of the State Department of Health would consider any proposal submitted on this question.

Dr. Davidson and Dr. Kirkland, representing the 6th and 7th Councilor Districts, reported on correspondence and conferences relative to a proposed transfer of one or more counties as part of those or other adjoining districts with special reference to Richland County.

On *motion* by Dr. Davidson, seconded by Dr. Huston and *carried*, these two Councilors were continued as a committee of two to study the question further and report at a later meeting.

Dr. R. W. DeCrow from the State Department of Health, representing Dr. Wm. H. Hartung, State Director of Health, was present and on invitation expressed interest in the health questions discussed at this meeting and the hope for close cooperation with the State Department of Health and the new Director.

Membership statistics submitted for the information of Council showed a total of 4,382 members to date for 1935—4,350 members at $5.00 dues and 32 members at $4.00 dues (the latter with rebate deducted before being transmitted to the State Association), and a total of membership dues collected to date of $21,883. Rebate checks were issued as follows: to individual members, 4,033; to the following county medical societies in lump sum checks in compliance with official request for rebate to the county society treasury: Mahoning County, 183; Hancock County, 42; Lucas County (Toledo Academy of Medicine), 124; a total rebate to date of $4,382, showing a net receipt from membership dues for 1935 of $17,533.

In connection with extra expenses, printing, postage, typewriter rent, clerical work, supplies, etc., a report showed extra expenses to date in connection with handling the rebate of $209.82 which did not include overtime and extra work of the bookkeeping department of the headquarters staff.

There being no further business submitted by the officers or Councilors, the Council adjourned to meet at the call of the President.

Signed: JAMES A. BEER, M.D.,
Acting Sec'y of Council, in the absence of Dr. Goodman.

—OSMJ—

NEW BOOKS

Methods of Treatment. Logan Clendening, M.D., Clinical Professor of Medicine, Medical Department of the University of Kansas; with special chapters on special subjects, by H. C. Anderson, M.D., Ursulla Brunner, R.N., J. B. Cowherd, M.D., Paul Gempel, M.D., H. P. Kuhn, M.D., Carl O. Rickter, M.G., F. C. Neff, M.D., E. H. Skinner, M.D., E. R. DeWeese, M.D. and O. R. Withers, M.D. Fifth edition. Price $10.00. The C. V. Mosby Company, St. Louis, publishers.

PERSONAL COMMUNICATION FROM DON K. MARTIN

To the Members of the Ohio State Medical Association:

After 16 years of most happy and satisfactory association with you and your fellow members, it is with reluctance and regret that I have resigned, effective March 15, as an employe of the Ohio State Medical Association.

My association with you and employment by you will always be a source of pleasant recollection, and I hope that the many personal friendships which have developed will continue.

I believe so thoroughly in the principles, policies and high purposes of the medical profession that I will continue my interest in the problems and activities of medical organization.

In my new position as manager of the Ohio Manufacturers' Association, which affords so many opportunities for the future that I felt I could not decline this offer, I will be in close touch with many of the functions of medical organization and hope to be of assistance to the Ohio State Medical Association from time to time.

With cordial and permanent regards and best wishes, I am,

Sincerely,

DON K. MARTIN,
Executive Secretary.

Meeting of Northern Tri-State Medical Association to Be Held at Lima on April 9; The Complete Program

Annual Meeting of the Northern Tri-State Medical Association will be held in Lima, April 9 at the Quilna Theater.

An interesting program, starting at 8 a. m. and closing with a banquet and evening session, has been arranged by the following officers of the association: President, Dr. H. E. Randall, Flint, Michigan; vice president, Dr. Edward P. Gillette, Toledo; secretary, Dr. G. E. Jones, Lima; treasurer, Dr. P. N. Sutherland, Angola, Indiana; counsellors, Dr. Charles Lukens, Toledo, Dr. W. H. Marshall, Flint, Michigan, and Dr. G. O. Larson, LaPorte, Indiana.

The program follows:

8:00-8:45 A. M. John Walker Moore, M.D., Dean of Univ. of Louisville, Louisville, Kentucky. "Studies on the Circulation in Cases of Hypertension".

8:45-9:30 A. M. Willard Bartlett, Sr., M.D., Asst. Prof. Clinical Surgery, Washington University, St. Louis, Mo. "Lessons Derived From a Five Year Morality Study".

9:30-10:15 A. M. R. L. Schaefer, M.D., Internist, Detroit, Michigan. "The Classification and Diagnosis of Dwarfism, and Therapeutic Results With the Pituitary Growth Hormone".

10:15-11:00 A. M. B. H. Nichols, M.D., Director of Roentgenology, Crile Clinic, Cleveland, Ohio. "The Roentgenological Aspect of Kidney and Ureter Tumors".

11:00-11:45 A. M. R. W. Waggoner, M.D., Associate Prof. Neurology, University of Michigan, Ann Arbor, Michigan. "The Diagnosis of Cerebral Lesions, or the Diagnosis of Brain Tumors".

AFTERNOON SESSION

1:00-1:45 P. M. Irving W. Potter, M.D., Obstetrician, Buffalo, N. J. "The Porro Operation in Obstetrics".

1:45-2:30 P. M. R. Wesley Scott, M.D., Prof. of Clinical Medicine, Western Reserve Medical School, Cleveland, Ohio. "The Heart After Forty".

2:30-3:15 P. M. Martin H. Fisher, M.D., Prof. of Physiology, University of Cincinnati, Cincinnati, Ohio. "Diagnosis and Treatment in the Nephritides".

3:15-3:30 P. M. Business Session.

3:30-4:15 P. M. Alan Brown, M.D., Prof. of Pediatrics, University of Toronto, Toronto, Ontario, Canada. "Errors in Diagnosis and Therapy in Pediatrics".

4:15-5:00 P. M. Ralph A. Kinsella, M.D., Prof. of Internal Medicine, School of Medicine, St. Louis, Mo. "Chronic Arthritis".

6:00 P. M. Banquet, Barr Hotel.

7:00 P. M. Max Cutler, M.D., Michael Reese Hospital, Chicago, Ill. "The Present Position of Radiation in the Treatment of Cancer".

8:00 P. M. Emil Novak, M.D., Associate Prof. of Obstetrics, University of Maryand, Baltimore, Md. "Recent Advances in Gynecological Endocrinology".

Sectional Meeting, American College of Surgeons, to Be in Cleveland, April 4 and 5

The Ohio-Michigan-Indiana-Ontario-New York-Pennsylvania sectional meeting of the American College of Surgeons will be held in Cleveland, Thursday and Friday, April 4 and 5 next. Headquarters will be at the Hotel Statler.

The Committee on Local Arrangements was directed by Dr. William E. Lower as chairman, and Dr. John Dickenson as secretary.

Following is a preliminary outline of the program:

THURSDAY, APRIL 4

8:00- 9:00	Registration.
9:00-12:00	Operative Clinics.
9:30-12:00	Hospital Conference.
12:30- 2:00	Medical Motion Pictures.
2:30- 5:00	Hospital Conference.
5:00- 5:30	Annual Meeting, Fellows of the College.
7:00- 8:00	Medicine Motion Pictures.
8:00-10:30	Scientific Session, General Surgery.
8:00-10:30	Scientific Session, Eye, Ear, Nose and Throat Surgery.
8:00-10:30	Hospital Round Table Conference.

FRIDAY, APRIL 5

9:00-12:00	Operative Clinics.
9:00-11:00	Cancer Clinic.
9:30-12:00	Hospital Conference.
12:30- 2:00	Medical Motion Pictures.
2:30- 5:30	Scientific Session, General Surgery.
2:30- 5:30	Scientific Session, Eye, Ear, Nose and Throat Surgery.
2:30- 5:00	Hospital Conference.
8:00-10:00	Community Health Meeting.

Among those who will take part in the program are:

Dr. Frederic W. Bancroft, New York City, Associate Professor of Clinical Surgery, Columbia University College of Physicians and Surgeons; Dr. George Crile, Cleveland, Director, Cleveland Clinic Foundation, and Chairman, Board of Regents, American College of Surgeons; Dr. Winchell M. Craig, Rochester, Neurosurgeon at Mayo Clinic; Dr. Robert B. Greenough, Boston, President, American College of Surgeons; Dr. LeRoy Long, Oklahoma City, Director, LeRoy Long Clinic; Dr. John O. McReynolds, Dallas, Ophthalmic and Aural Surgeon, St. Paul's, Parkland, and Methodist Hospitals, Scottish Rite Hospital for Crippled Children; Dr. Charles L. Scudder, Boston, Consulting Surgeon, Massachusetts General Hospital; Dr. Frederic A. Beasley, Waukegan, Professor of Surgery, Northwestern University Medical School; Dr. Malcolm T. MacEachern, Chicago, Associate Director, American College of Surgeons, and Director of Hospital Activities; Robert Jolly, Houston, Superintendent, Memorial Hospital, and President, American Hospital Association; and Dr. M. N. Newquist, Chicago, Department of Industrial Medicine and Traumatic Surgery, American College of Surgeons.

—OSMJ—

Actions Against Corporate Optical Firms Filed in Ohio and U. S. Courts

A petition in quo warranto has been filed in the Ohio Supreme Court by Attorney General John W. Bricker against the Buhl Optical Company, a corporation licensed to do business in Ohio, asking that the corporation be ousted from doing business in this state.

The petition alleges that the Buhl company has violated its franchise permitting it to do business in Ohio as a manufacturer, seller, etc., of lenses, glasses, reflectors, etc., by carrying on the practice of the profession of optometry, both under its actual name and under the names of registered optometrists, in violation of Section 8623-3 of the General Code, which makes it illegal for a corporation to engage in the practice of a profession.

The filings on behalf of the Attorney General were by E. G. Schuessler, a member of the Attorney General's staff.

Another optical firm—Dr. Ritholz Optical Company—which has a number of stores doing business in Ohio, has been enjoined by the U. S. District Court, Chicago, from "using misleading and deceptive advertising; from advertising of 'free examination of eyes', 'free consultations', etc.; from advertising of offers for a limited period; from the use of inaccurate and misleading comparative prices; and from permitting salesmen to display certificates or to wear distinctive wearing apparel to convey the impression inaccurately that they are optometrists or technical men".

The action was based on alleged violations of certain sections of the Retail Code, the Optical Retail Code, the Dental Laboratory Code, and the Optical Manufacturing Code.

Benjamin D. Ritholz and his associates have filed a petition in the same court asking that the consent degree be vacated.

—OSMJ—

Mental Deficiency Meeting

The annual meeting of the American Association on Mental Deficiency will be held at the Hotel Palmer, Chicago, Thursday, Friday and Saturday, April 25, 26 and 27. The Thursday and Friday sessions will be devoted to studies on Mongolism; Birth Injury as an Etiological Factor in Mental Deficiency; Mental Disorders in Mental Deficiency; The Problem of Sterilization; Defective Delinquency and its Relation to Penal Institutions; Community Supervision of the Paroled Mental Defective; and Newer Methods in Institutional Training for Community Life.

DR. TUCKERMAN HONORED BY CLEVELAND ACADEMY AS TRIBUTE TO HIS LONG AND DISTINGUISHED SERVICE IN MEDICAL ORGANIZATION IN OHIO

DR. J. E. TUCKERMAN, Cleveland, for many years chairman of the Committee on Medical Defense of the Ohio State Medical Association, and a member of the House of Delegates, a former member of the Council, and in many other respects one of the outstanding figures in the activities of medical organization in Ohio, was the recipient of a unique and distinct honor on February 18 when he was awarded the title of Honorary Secretary of the Cleveland Academy of Medicine in honor of his long and distinguished service in the academy.

The following account of the presentation to Dr. Tuckerman of an illuminated parchment certifying his appointment by the Board of Directors of the Academy as Honorary Secretary was published in the March, 1935, *Bulletin of the Cleveland Academy of Medicine* and reveals why his Cleveland colleagues saw fit to so honor him:

"Thirty-three years of continuous service to the Academy was the basis for the award to Dr. Jacob Edward Tuckerman of the title of Honorary Secretary for life, at the regular meeting of the Academy, February 18th. In an informal, but impressive ceremony, before the five hundred members who were assembled in the Medical Library Auditorium, Dr. Lester Taylor, President, presented to Dr. Tuckerman an illuminated parchment on which was inscribed the action of the Board of Directors.

"Before making the presentation, Dr. Taylor called upon Dr. George Edward Follansbee to present a citation of Dr. Tuckerman's services. Dr. Follansbee spoke as follows:

" 'Dr. Tuckerman—The Academy of Medicine has honored itself as well as you by appointing you Honorary Secretary in recognition of your many years of faithful and valuable service in the organization.

" 'Of a membership of 1353 there are one-hundred and twenty-two who have been members of the organization longer than you but ne one of them has been continuously active in organizational matters as long. Less than a year following your graduation in 1902 you became an active member on the recommendation of Drs. W. H. Merriam and Frank E. Bunts and the approval of Dr. W. E. Bruner, Chairman of the Membership Committee. There could not have been a higher grade of sponsorship. The fact that you were the son of Dr. L. B. Tuckerman, the Doctor Tuckerman, of Cleveland and Ohio, was added recommendation if any were needed, for your father was one of the best, most widely known physicians in the state. He was a power in the community, honest in his thinking, with the courage of his convictions and a sympathy with the human side of life that endeared him to all those who came in contact with him. He was a great stimulant to the younger members of the profession who were privileged to come under his influence. The Good Book says "the sins of the fathers shall be visited upon their children." Occasionally the virtues of the fathers are similarly visited. And this is true tonight.

" 'One of the sad thoughts that must come on such a happy occasion as this is that those to whom we may owe most for our success in life cannot themselves be present to see the result of their influence and feel the pride which justly would be theirs. I knew your father well and I would rather be seated next to him in this audience tonight, seeing his beaming face and feeling his swelling pride, than standing here enjoying the embarrassment that your modesty compels and that you so successfully try to conceal.

" 'The same year you joined the Academy you entered its official life as an Alternate Delegate from the society to the Ohio State Association. From that date you have maintained an official position. The list with dates is in the official record but is too long to detail here. Your activities have ranged from committee member to President and have been chiefly concerned with those matters influencing the relationship of the profession with the public in its public health, economic and ethical aspects. It is a record to be proud of. No other member of this body can boast of an official service beginning in the first year of membership and being continuous to the end of life as this honorary appointment provides.

" 'You also have been active in the State Medical Society. In 1915 as chairman of the special committee establishing medical defense you were the sponsor and outstanding administrator of that state association activity. You have been the Chairman of the State Medical Defense Committee since that time. You have served on the Publication Committee, the Auditing Committee and have been an Alternate Delegate from Ohio to the American Medical Association. You also have served on the Council of the State Association and for many years have been a member from Cuyahoga County in the House of Delegates and

served in practically every capacity as chairman or member of its various committees.

"'We enjoin you—do not hide this parchment away. Carelessly let it lie, where out of the tail of your eye you can see others pick it up and view it with admiration and envy—and smile in your heart that you, living, have heard what usually is said only after death.

"'We congratulate you and hope you will bear this honor for many years to come.'

"In presenting the leather bound parchment to Dr. Tuckerman, Dr. Taylor pointed out that the Board of Directors was not only honoring Dr. Tuckerman, but was insuring for the Academy the life long services of Dr. Tuckerman in an advisory capacity."

Study Outline No. 10

CANCER

By FRANK L. RECTOR, M. D.,
EVANSTON, ILLINOIS

1. Definition
2. Classification
   - A. Microscopic
     - a. By type of tissue
     - b. By origin of tissue
   - B. Macroscopic
     - a. By site of lesion
     - b. By response to irradiation
3. Distribution
   - A. Age
   - B. Sex
   - C. Race
   - D. Economic class
4. Method of Growth
   - A. Infiltration
   - B. Metastasis
5. Etiology
   - A. Biologic
     - a. Inheritance factor
     - b. Familial susceptibility
     - c. Found in physiologically old tissues
   - B. Pathologic
     - a. Irritation
       1. Mechanical
       2. Chemical
       3. Thermal
     - b. Relation of trauma to etiology
6. Diagnosis
   - A. Early symptoms
     - a. No pain, (bone and nerve cancer excepted)
     - b. Persistent lump
     - c. Unhealing sore
     - d. Unnatural blood stained discharge
     - e. Persistent indigestion
     - f. Change in size or color of warts or moles
   - B. Late symptoms
     - a. Pain, usually severe
     - b. Interference with function of part
     - c. Ulceration, if near surface
     - d. Toxin absorption
     - e. Loss of weight and cachexia
   - C. Biopsy, when and how made
   - D. Relation of pathologist to diagnostic procedures
   - E. Transillumination of breast
   - F. Lugol's solution for cancer of cervix
   - G. Pituitary hormone test for testicular teratomas
7. Prognosis
   - A. Early, good
   - B. Late, unfavorable
8. Prevention
   - A. Precancerous lesions
     - a. Leucoplakia
     - b. Keratoses, especially senile
     - c. Chronic cervicitis and other chronic inflammations
   - B. Avoidance of prolonged irritation
9. Treatment
   - A. Curative
     - a. Surgery
     - b. Irradiation with *X*-ray or radium
   - B. Palliative
     - a. Surgery
     - b. Irradiation with *X*-ray or radium
10. Follow-up Methods
    - A. Necessity of following patient for at least five years
    - B. How accomplished. Methods and agencies employed
11. Organization of Facilities for Diagnosis and Treatment
    - A. Tumor clinics
      - a. Required hospital facilities and personnel
    - B. Pathological conferences
    - C. Staff conferences
12. Research
    - A. Laboratory
      - a. Biological
        1. Genetics
        2. Tissue culture
        3. Transplantation of tumor tissue

4. Induction of tumors by external agents, as tar
b. Chemical
c. Physical
d. Pathological

B. Clinical
a. Value of different types of therapy
b. Pre and postoperative radiation
c. Development of new diagnostic aids

C. Statistical
a. Geographic distribution
b. Deaths and death rates
c. Hospital experience

13. Control Measures
A. Education of laity
a. Appreciation of early signs
b. Reduction of waiting period before physician is consulted
c. Periodic physical examination
d. Possible aids to prevention—hygiene and cleanliness

B. Education of medical profession
a. Appreciation of early signs and symptoms and value of prompt diagnosis and competent treatment
b. Elimination of waiting period for more positive signs

14. Social Aspects of Cancer Problem
A. Economic problems involved
B. Reaction of cancer patient to knowledge of disease
C. Reaction of patient's family
D. Place of social worker in the cancer field

15. Suggestions for Papers
A. Problems in cancer research
B. Diagnosis and treatment of early cancer
C. Organization of facilities for diagnosis and treatment
D. Irradiation in cancer therapy
E. Treatment of advanced cancer
F. Follow-up methods on cancer patients
G. The layman's responsibility in control of cancer
H. The physician's responsibility in control of cancer
I. Prevention of cancer
J. Precancerous lesions and their treatment
K. Differential diagnosis in malignancy

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—OSMJ—

Youngstown Post-Graduate Day to Be Held April 25; Mayo Clinic Group to Present Program

The Eighth Annual Post Graduate Day of the Mahoning County Medical Society will be held on Thursday, April 25, at Youngstown, with members of the faculty of Mayo Clinic, Rochester, Minnesota, presenting the program. The morning and afternoon sessions will be held at Stambaugh Auditorium, and the dinner and evening session will be held at the Youngstown Club. Registration fee, including dinner is $5.00.

The morning session will include the following papers:

9:00 A. M. "Spondylolisthesis as a Factor in the Cause of Backache", by Dr. Henry W. Meyerding, Associate Professor of Orthopedic Surgery, Mayo Clinic.

10:00 A. M. "The Treatment of Gastro-intestinal Neuroses", by Dr. Walter C. Alverez, Professor of Medicine, Mayo Clinic.

10:00 A. M. "The Functions of the Liver", by Dr. Frank C. Mann, Professor of Experimental Surgery and Pathology.

Program for the afternoon session is as follows:

1:00 P. M. "Rectal Cancer; Management and Prognosis", by Dr. C. F. Dixon, Associate Professor of Surgery.

2:00 P. M. "The Functions of the Spleen", by Dr. Mann.

3:00 P. M. "The Clinical Aspects of Fibrosarcome of the Soft Tissues of the Extremities", by Dr. Meyerding.

Dinner at the Youngstown Club, at 6:00 P. M., will be followed by papers on "The Diagnosis of Gastro-intestinal Disease Purely from a Good History", by Dr. Alverez, and "Essential Operations for Chronic Ulcerative Colitis", by Dr. Dixon.

WORKMEN'S COMPENSATION

Digest of Recent Court Decisions and Excerpts of Interest to Physicians Pertaining to Industrial Commission Cases and Administrative Procedure.

THERE is a distinction between medical and legal trauma and the medical trauma produced by a microbe or a microscopic foreign substance coming in contact with an uninjured mucous membrane of the human body during an uncertain period of time is not such trauma as is contemplated by the Ohio Workmen's Compensation Law, the Ohio Supreme Court held in a recent decision on an appeal filed from the rejection of a claim by the State Industrial Commission. *(No. 24740,129 O. S., Industrial Commission of Ohio v. Armacost).*

Because of the interesting and important medical angles of the case, the major portions of the statement of facts and decision are herewith quoted.

On January 7, 1928, the claimant, Mary Armacost, a saleswoman in the dress goods department of a Dayton department store filed with the State Industrial Commission an application for compensation for alleged infection to both eyes, said to have been caused by dyes in materials she handled. Her disability was diagnosed as chemical conjunctivitis. Her application was refused on the ground she had not suffered a compensable injury and because chemical conjunctivitis is not a compensable occupational disease under the Ohio statutes. The claim was rejected on rehearing and appeal taken to the Common Pleas Court which held the claimant's case was compensable. The Court of Appeals affirmed the decision of the lower court. The case was prosecuted on error to the Supreme Court.

The claimant alleged that particles of dye from dresses she had handled became attached to her hands and were blown about in the air surrounding her face. She alleged that these particles came in contact with the mucous membrane covering her eyes, set up a violent irritation, and made medical services necessary.

"There is no testimony," the court stated, "to the effect that particles of dye adhered to claimant's hands and were communicated to her eyes therefrom by the rubbing process, or that such particles floated in the atmosphere in the store room in question, and there is no testimony to establish a casual connection between these particles and claimant's eye condition. All that was proven was the fact that at the time complained of by claimant, she handled ready-made dresses, that her eyes became infected, she went to a doctor, told him the nature of her work, and he diagnosed her case as chemical conjunctivitis because of its stubbornness. She says she never rubbed her eyes with her hands, and she washed her hands thrice daily, at least. The doctor made no microscopic examination. At no point in his testimony does Dr. ..... say that the particles of dye from the dress goods caused claimant's conjunctivitis. He simply says that particles of dye could have caused the condition, but as a matter of fact he did not know what caused it.

"It would seem, even to a stranger to the science of medicine, that a microscopic examination would have developed the fact whether or not particles of dye had lodged upon the mucous membrane of claimant's eyes, and it could have been further ascertained whether or not the dress goods handled by claimant gave off dry particles. This microscopic examination was not made. Why? We do not know.

"To permit claimant in this case to participate in the State Insurance Fund would be to encourage speculation in cases of this character. Chemical conjunctivitis not coming within the category of occupational diseases defined by our Legislature, it would be necessary for claimant to allege and prove traumatic injury. She does, in a way, allege trauma, and Dr. ..... endeavors to, and probably does, from a medical standpoint, classify her affliction as the result of trauma. He says:

" 'If you will refer to Deschwemitz, who is an eminent authority on diseases of the eye, you will find this kind of trouble mentioned under various forms of conjunctivitis. There are a lot of different kinds he mentions, among which are toxic conjunctivitis which he also classifies as traumatic, because due to some external irritant.'

"This probably fills the bill as a definition of medical trauma, but is it legal trauma? Is it the kind of trauma the General Assembly had in mind when it said in the enactment of Section 1465-68, General Code, 'Every employe *** who is injured *** in the course of employment' shall be paid compensation from the State Insurance Fund?

"If it were proven in this case and this court should hold that when these particles of dye, so small that they could not be seen with the naked eye, came in contact with the uninjured mucous membrane of the eye, the legal requirements of trauma under the laws of Ohio were satisfied, then we would be obliged to hold that when any microbe entered the human body from the outside and lodged upon an uninjured mucous membrane that trauma resulted. Such a holding would up-

set all legislation relative to occupational diseases, as it is a well known fact that practically all disease is communicated to the human body by means of some form of bacilli, a restricted form of microbe.

"For the purpose of the case, let us admit that over a period of time the dress goods in question gave off dye particles and they were communicated to the eyes of the claimant in the course of her employment. She is not within the purview of the Workmen's Compensation Law. Her eye condition might be caused by a single particle of dye, or it might be caused by the accumulation of dye particles for days, weeks or months. She says nothing unusual happened to her. Hence there was no accidental injury.

"The judgment of the Court of Appeals is reversed and final judgment rendered for plaintiff in error, the Industrial Commission of Ohio."

* * *

Compensation paid under the provisions of the Workmen's Compensation Law, after it has been received by an injured workman and placed in a bank by him, is subject to attachment or execution the same as any other funds so deposited by such injured workman, according to a recent opinion of Attorney General John W. Bricker. (Opinion No. 3896).

* * *

The following analysis of the 1934 record of Ohio industry by Thomas P. Kearns, superintendent of the Division of Safety and Hygiene, State Industrial Commission, was published in a recent issue of *The Ohio Monitor*, official publication of the Commission:

"The 1934 accident record of Ohio industry presents an interesting study. It represents both gains and losses for the cause of safety, but taking into consideration the important matter of exposure and unusual economic conditions it represents really a gratifying gain in accident prevention results.

"During the year, a total of 159,248 injury and occupational disease claims were filed with the Industrial Commission. This number includes 956 fatalities, 5 permanent total disabilities and 1,443 permanent partial disabilities, the latter figure representing loss of, or loss of use of, some member or members of the body.

"Among the losses sustained by Ohio workers were 129 eyes, 29 arms, 15 hands, 23 legs, 2 feet, 971 whole fingers, 632 parts of fingers and 72 toes.

"While such a tragic casualty list cannot be completely reconciled with the time and attention given to accident prevention effort, the increases in both accident frequency and severity were fully anticipated by all who make a study of accident evils and the unusual conditions which are calculated to accentuate normal hazards.

"Without the intent of offering an apology for the increases noted or attempting to establish an alibi for failure to achieve better results, we feel it is due the employers and workers of Ohio that they get some insight into the facts behind the figures.

"According to the only research figures available, pending payroll reports for the year, employment in Ohio increased 19.3 per cent in 1934 as compared with 1933. In the same period, injury and occupational disease claims increased 22.2 per cent. This ratio of increase would indicate that safety suffered reverses, but a further analysis of the year's record robs these figures of some of their significance.

"A study of the tentative summaries of the year shows that while medical cases only increased 26.7 per cent over 1933, compensable cases increased only 6.6 per cent and fatalities only 5.5 per cent, while permanent total disability cases show a decrease of 16.6 per cent. This would indicate that accident severity is under better control than accident frequency, were it not for the regrettable fact that permanent partial disability cases increased 22.3 per cent, one-tenth of one per cent more than the aggregate of injury cases.

"Pending closer analysis of accident causes, not possible at this time, we are unprepared to say whether this exceptionally heavy increase in member losses is due to lack of proper safeguards or failure of the human element. However, the burden of this increase coming through losses of fingers, we are inclined to believe that safeguarding of machinery has not reached the point of adequacy that code requirements and safety surveys warrant. The eye losses, too, would suggest a lamentable disregard of safe practice in the use of goggles, which might be chargeable either to employee indifference or supervisory negligence.

"But disregarding the question of responsibility, the fact remains that the trail of death and suffering left by our accident evils during the past year is inexcusable and presents a strong indictment of industry's apparent indifference to the enormity of the record. It is all too evident that the seeds of safety thought sown during the year have too often fallen on barren ground, neutralizing the positive advances made by many industrial groups who have labored diligently and incessantly to reduce the number and severity of occupational injuries.

"As we have said before, few safety workers in industry anticipated anything but an increase in the record under existing conditions and while all should be pleased that major injuries have been held so well in hand, we cannot ignore the crying need for more diligent and more enlightened effort if the record for 1935 is to show improvement. And we cannot be content with the thought that the industrial record of Ohio compares favorably with those of other states and that of the nation as a whole.

"None of us are sufficiently sanguine to hope for the time when accidents will be completely controlled during our generation but there is full warrant for the thought that thousands of these accidents which are preventable, can and will be prevented, if we continue with intelligence and persistence along the course we have mapped."

—OSMJ—

The sixth annual session of the All Ohio Safety Congress will be held at the Neil House, Columbus, Ohio, on Tuesday, Wednesday and Thursday, April 23, 24 and 25. The details incident to the formulation of the programs for the general sessions is in the hands of the Division of Safety and Hygiene, State Industrial Commission.

First of Series of Post-Graduate Days, Sponsored by Akron Profession, Held at City Hospital on Feb. 20

In line with the movement to take post-graduate training to the physician in active practice, the Summit County Medical Society sponsored on February 20 the first of a series of four Post-Graduate Days at various Akron Hospitals.

The committee in charge of arranging for the post-graduate programs is headed by Dr. P. R. Adams whose primary purpose in arranging the programs was to enable the general practitioner to secure the specialist's viewpoint and to afford the specialist an opportunity to get the general practitioner's views on medical problems.

The first of these post-graduate meetings, held at the Akron City Hospital, was attended by 180 physicians from Akron and surrounding cities and was pronounced a great success by all in attendance.

The complete program, arranged by Dr. C. E. Updegraff, chairman, Dr. J. H. Weber, Dr. G. A. Ferguson, and Dr. D. B. Lowe, was as follows:

AFTERNOON SESSION

1:30 P. M. Dr. F. A. Smith "Treatment of Diabetes Mellitus"
2:00 P. M. Dr. L. C. Eberhard "The Acute Abdomen"
2:30 P. M. Dr. M. J. Pierson "Foreign Body of Air and Food Passages" (Lantern Slides)
3:00 P. M. Dr. S. B. Conger "Management of Protracted Labor"
3:30 P. M. Dr. F. H. Cook "Differential Diagnosis of Glaucoma and Oveitis"
3:45 P. M. Dr. L. A. Witzeman
(a) "Treatment of Sinusitis"
(b) "Electro-Coagulation of Tonsils"
4:00 P. M. Dr. Simon Morgenroth "Heart Disease with Electrocardiograms"

DEMONSTRATION AND EXHIBITS

4:30 P. M. Dr. E. L. Saylor Museum of Fresh Tissue Exhibit
Dr. R. A. Ober Management and Control of Fractured Mandible and Maxilla
Dr. C. M. Clark
(a) Malignancies of the Mouth
(b) Esophageal Stricture
(Demonstration of cases)
Dr. A. E. Davis and
Dr. I. R. Birnbaum Demonstration and Treatment of Fractures
6:00 P. M. Dinner

EVENING SESSION

7:00 P. M. Dr. C. L. Hyde "Treatment of Tuberculosis in the Home" (Slides or films or both)
7:30 P. M. Dr. J. N. Weller, "Non-Tuberculous Pulmonary Infections" (X-ray films)
8:00 P. M. Dr. C. E. Jelm "Traumatic Conditions of the Bladder and Urethra" (X-ray films)
8:30 P. M. Dr. W. A. Hoyt "Skull Fractures and Injuries to the Head" (X-ray films)
9:00 P. M. Dr. A. H. Stall "*X*-ray Diagnosis of Gastric Ulcers" (Films or Drawings)

The Committee in charge of arrangements for the City Hospital Post Graduate Day:

C. E. Updegraff, Chairman; J. H. Weber, G. A. Ferguson, D. B. Lowe.

—OSMJ—

Ohio Physicians Are Advised to Disregard Demands of Optical Retail Trade Code Authority, Pending Outcome of Protest

Ohio physicians, especially oculists, will be interested in a statement recently issued by the Bureau of Legal Medicine and Legislation of the American Medical Association relative to a letter of the Optical Retail Trade Code Authority, 7 East 44th Street, New York City, organized under the National Industrial Recovery Act, addressed to "Oculists and Physicians Dispensing Ophthalmic Products".

The letter, as physicians who have received it of course know, states that "physicians selling glasses or servicing prescriptions" come fully within the scope of the Optical Retail Code.

In most cases the letter has been accompanied or followed by a demand by the Optical Retail Trade Code Authority that the physician to whom it is addressed fill out a questionnaire relative to the nature and extent of the physician's optical business and pay assessments amounting to $3.00 for each employee in his service, the assessment being for the support of the Optical Retail Trade Code Authority, a trade organization.

Relative to the statements made in the letter and the demand for payment of assessments by physicians, the memorandum of the Bureau of Legal Medicine and Legislation of the A.M.A. said:

"The National Industrial Recovery Act does *not* purport in any way to regulate or control the practice of medicine. It specifically relates to "industry" and "trade" and to industrial and trade associations or groups. It relates only to transactions in or affecting interstate or foreign commerce. Under no provision of the act can a physician who confines his work to rendering professional medical services be subjected to any provision of the code or to any assessment under the code.

"A person who on his *own account commercially buys and sells* eyeglasses and spectacles and makes a *commercial* profit on the transaction is presumably within the purview of the Optical Retail Trade Code, even though he happens to be a physician. It is believed, however, that a physician who buys and sells eyeglasses and spectacles *only as the agent of patients for whom he prescribes them and without making any commercial profit on the transaction* is not within the terms of that Code. The fact that a physician

charges for his *professional* services in prescribing and fitting glasses and spectacles does not alter the situation.

"The American Medical Association has protested against the attempt of the Optical Retail Trade Code Authority to bring physicians as such within the scope of the code that it administers. Pending the adjustment of those protests, physicians who are engaged in strictly professional work are advised to refrain from answering the questionnaire that the Optical Retail Trade Code Authority has sent to them and to refrain from paying the attempted assessment for the support of that Code Authority."

Ohio physicians who have received the communication of the Optical Retail Trade Code Authority should follow the advice issued by the A.M.A. Bureau of Legal Medicine and Legislation and to watch for a statement of the outcome of the protest filed by the A.M.A. which will be published in *The Journal of the American Medical Association* and *The Ohio State Medical Journal.* Through the efforts of medical organization it is hoped that the present ruling of the trade authority will either be modified or withdrawn.

—OSMJ—

Supreme Court Upholds Liquor Control Department in Whisky Labelling

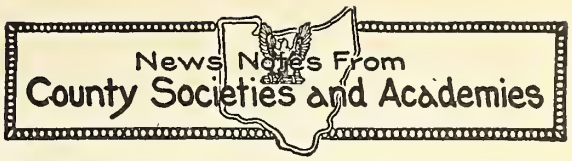
The Ohio Supreme Court has denied a writ in mandamus to compel the State Department of Liquor Control and its director to comply with the Ohio Pure Food and Drug Act which requires all whisky sold or offered for sale in Ohio to be labelled in accordance with the definition of "whisky" found in the food and drug act. (No. 24793,129 O. S., The State, ex rel. Wetterstroem, v. Department of Liquor Control of the State of Ohio et al.)

The syllabus of the court's decision sets forth the following:

1. The Liquor Control Act, Section 6064-1 et seq., General Code, is a special, all-inclusive act controlling traffic in intoxicating liquors and was adopted at a period later than the enactment of the Pure Food and Drug Law; in so far as they are incompatible the provisions of the Liquor Control Act must govern.

2. Section 5777, General Code, relative to the sale and adulteration of drugs, including whisky as pharmacopoeially defined, applies only to whisky when manufactured and sold as a drug; while the Liquor Control Act deals with intoxicating and spirituous liquors "fit for use for beverage purposes *** by whatsoever name called".

3. The Department of Liquor Control and its director are not amenable to and need not comply with the provisions of Section 5777, 5778 and 5784, General Code, of the Pure Food and Drug Law, pertaining to the ale and labelling of whisky as a drug.



First District

ACADEMY OF MEDICINE OF CINCINNATI

(H. J. Lavender, Secretary)

Meetings of the Academy held during March were as follows:

March 4—General Session. Program: "Case Finding in University Health Services", by Dr. Lawrence B. Chenoweth. "Eye Observations of Diagnostic and Prognostic Value to General Medicine", by Dr. Donald J. Lyle; discussion by Dr. Horace W. Reid and Dr. Mary K. Asbury.

March 11—General Session. Program. "Sinus Thrombosis", by Dr. M. F. McCarthy. "Medical Management of Sinus Thrombosis", by Dr. Stanley E. Dorst; discussion by Dr. Samuel Iglauer.

March 18—General Session. Program: "The Pathology of Cholelithiasis and Its Bearing on Diagnosis and Treatment", by Dr. Dallas N. Phemister, Department of Surgery, University of Chicago.

March 25—General Session. Program: "The Injection Treatment of Varicose Veins", by Dr. Clyde S. Roof; discussion by Dr. Robert Carothers and Dr. Jacob J. Longacre. "Nutritional Anemia in Infancy", by Dr. George M. Guest.—Bulletin.

Butler County Medical Society met at Middletown Hospital on Wednesday, March 6. Legislative problems were discussed and letters to local legislators pertaining to bills in which the medical profession is interested were given the approval of the society. K. A. Browning, Butler County FERA administrator, explained the medical relief program and stated that it would become operative within one week, after having been delayed for a year. Dr. Wm. F. Vinnedge and Dr. H. W. Seff were accepted for membership.—V. E. Roden, M.D., Secretary.

Second District

Green County Medical Society met Friday March 8, in Xenia. "Functional Disturbances of the Digestive System" was the subject of an address by Dr. E. W. Shank, of Dayton. In his address, Dr. Shank outlined the clinical picture, the need for careful history, thorough examination, and adequate laboratory study upon which to base the diagnosis, and gave very concrete advice as to the essentials of care—physical, psychological and dietary. Dr. Ernest Ekermeyer and Dr. Van der Veer Taylor were accepted for membership.—Reyburn McClellan, M.D., Secretary.

Miami County Medical Society held its regular meeting on Friday, March 8, at Stouder Hospital, Troy, followed by a dinner at 6 o'clock. The pro-

gram of the afternoon included a paper by Dr. J. F. Beachler, of Piqua, who spoke on "The Early Diagnosis and Prohphylaxis of Female Genital Carcinoma". Discussion was opened by Dr. K. F. Lowrey, of Troy.—Bullletin.

Montgomery County Medical Society held its regular meeting on Friday evening, March 1 in the auditorium of the Fidelity Medical Building, Dayton. A symposium on "Blood in Infancy and Childhood" was presented. Dr. M. F. Osterlin spoke on "Normal and Theoretical Considerations" and Dr. W. B. Taggart, discussed "Abdominal Conditions". It was announced that the annual "Spring Roundup" sponsored by the Dayton Parent-Teachers' Association, for the examination of children entering school for the first time will be held the last two weeks of April.

On March 15, the Society met at the Dayton State Hospital, following a complimentary dinner. Dr. Robert A. Kehoe, College of Medicine, University of Cincinnati, discussed "Recent Experimental and Clinical Developments in the Problem of Lead Poisoning."—Bulletin.

Preble County Medical Society met for its regular meeting on Thursday evening, February 14, at Seven Mile Tavern, Eaton. Following a dinner, Dr. Louis G. Herrmann, of Cincinnati, spoke on "The Diagnosis and Treatment of the More Common Arterial Diseases of the Extremities".—News Clipping.

Shelby County Medical Society held its regular meeting on Friday evening, March 1, in Sidney. A symposium on "Trichinosis" was presented, with Dr. R. E. Paul of Botkins, as speaker, followed by general discussion.—News Clipping.

Third District

Auglaize County Medical Society held its regular meeting on Thursday evening, February 21, at the court house in Wapakoneta. An address on "Cause of Mental Disorders", was given by Dr. R. E. Bushong, superintendent of the Lima State Hospital for the Criminal Insane. Dr. R. S. Hunter, Wapakoneta, gave an interesting report of the recent trip of the Travel Club of Lima to New York clinics. Twenty physicians from various parts of the county attended the meeting.—News Clipping.

Hancock County Medical Society met at the Elks Club, Findlay, on Thursday evening, February 7, for its regular monthly dinner. Dr. R. C. Van Buren, of Carey, and Dr. H. J. Miller, of McComb, were accepted as members. Dr. E. J. McGrath, of the University of Cincinnati, guest speaker, gave a very interesting talk on "Peripheral Vascular Disease".—R. S. Rilling, M.D., Secretary.

Mercer County Medical Society, held a dinner meeting on Thursday evening, February 21, at the Manhattan Restaurant, Celina, with a splendid attendance. Hosts for the meeting were Drs. R. J. Beare and W. J. Wilke. Following the dinner, Dr. Robert Carothers, of Cincinnati, addressed the Society on the subject of "Fractures".—News Clipping.

Seneca County Medical Society held its regular meeting at the Shawhan Hotel, Tiffin, on Thursday evening, February 21. Newer methods of anesthesia were discussed by Drs. J. Gould, E. C. Strawbridge, and Norris Gillette of Toledo. Moving pictures on the same subject were shown following the talks. At a business session, Dr. John Leahy was elected to membership.—News Clipping.

Marion County Academy of Medicine met Tuesday evening, March 5, in Marion for its regular meeting. Dr. B. L. Good, of Van Wert, presented a paper on "*X*-ray and Radium Treatment of Cancer". Mr. H. M. Gee, superintendent of Van Wert County Hosiptal, was a guest of the Academy.—News Clipping.

Fourth District

Defiance County Medical Society held its regular monthly meeting on Tuesday evening, February 26, at the Defiance hospital. Papers were read by Drs. J. U. Fauster, Sr., D. J. Slosser, and F. A. Rieckhoff, Defiance, and Dr. W. E. McKee, of Ney.—News Clipping.

Sandusky County Medical Society held a well-attended meeting on Thursday evening, February 28, at Fremont. Dr. Fred M. Douglass, of Toledo, presented a paper on "The Management and Analysis of Acute and Ruptured Appendicitis".—Carl J. Wolf, M.D., Secretary.

Fifth District

ACADEMY OF MEDICINE OF CLEVELAND

(Justin A. Garvin, M.D., Secretary)

Programs for meetings of the Academy, held during March, were as follows:

March 1—Clinical and Pathological Section: "A Case of Fragilitas Ossium", Dr. H. G. Sloan; "Osteochondritis of the Hip", Dr. M. Harbin; "Fistula Between Carotid Artery and Cavernous Sinus, Demonstration of a Case", Dr. C. S. Beck; "The Use of Alternating Positive and Negative Pressure in the Treatment of Peripheral Vascular Disease", Dr. E. F. Bright; "Operative Treatment of Sprengel's Deformity", Dr. W. C. McCally; "Preliminary Nephrostomy in Pyonephrosis", Dr. J. J. Joelson; "An Important Factor in the Mortality Rate following Operation for Chronic Peptic Ulcer", Dr. H. O. Studley.

March 8—Experimental Medicine Section and Cleveland Section of the Society for Experimental Biology and Medicine: "Blood Sugar Changes after Administration of Dinitrophenol", W. F. Ashe, Jr., A.B. (by invitation); "The Acid-Base Balance of the Blood in Hyperthermia", W. H. Danielson, M.S. (by invitation) and Dr. R. M.

Stecher; "Effect of Dinitrophenol on the Oxygen Uptake of Rat Tissue", Edward Muntwyler, Ph.D.; "A Method for the Estimation of Serum Iron", F. C. Bing, Ph.D., and R. F. Hanzal, Ph.D.; "Further Studies on the Creatine Content of Heart Muscle", C. R. Linegar, Ph.D., and V. C. Myers, D.Sc.; "A Note on the Pathology of Bone Marrow", Dr. F. R. Miller and Dr. A. N. Chinn.

March 13—Obstetrical and Gynecological Section: "Maternal Health, a Study of 4000 Patients Admitted for Contraceptive Advice and Treatment", Dr. Ruth I. Robishaw; "Significance of Pathologic Changes in the Uterine Cervix", Dr. J. L. Bubis; "Tri-Brom-Ethynol (Avertin) Pre-Anesthesia in Gynecology, Review of 559 Cases", Dr. J. L. Reycraft.

March 15—Regular Academy Meeting; "Some Aspects of Arterial Hypertension", Dr. Ralph H. Major, Professor of Medicine, University of Kansas, Kansas City, Kansas.

March 19—Military Medicine Section: "From Civies to Khaki and Back to Musti", Dr. George P. O'Malley.

Ashtabula County Medical Society entertained with a dinner dance on Tuesday evening, February 12, to which were invited wives of members, dentists and pharmacists and their wives. Dr. E. H. Merrell, of Geneva, president of the Society, acted as toastmaster.—News Clipping.

Huron County Medical Society, at a meeting held Wednesday evening, February 13, elected the following officers for 1935: President, Dr. L. H. Hayhurst, Greenwich; vice president, Dr. L. H. Whisler, Willard; secretary-treasurer, Dr. C. B. Thomas, Greenwich; legislative committeeman, Dr. George Linn, Norwalk; delegate to the State Meeting, Dr. O. J. Nicholson, Norwalk, and alternate, Dr. A. H. Kimmel, Norwalk. Following the business session, Dr. J. P. Rankin, of Elyria, gave an address on the subject of "Thyroid".—News Clipping.

Lake County Medical Society met for its regular monthly meeting on Tuesday afternoon, February 26, at the Lake County Memorial hospital, Painesville. Films on the modern methods of anesthetics were shown following the regular business meeting.—News Clipping.

Lorain County Medical Society held its regular meeting on Tuesday evening, February 12. Following a dinner and the usual business routine, members of the society listened to an address by Mr. L. B. Hindman, Executive Secretary of the Lorain County Tubercular and Public Health Association. Mr. Hindman asked the support of the society in bettering conditions of the youngsters tubercularly inclined, and under-nourished. He urged the development of a plan for building clean airy cottages for these children rather than spending tremendous sums for architecturally splendid buildings for the care of these young people. After a vote of thanks to the speaker for his able and instructive address, and the appointment of a committee of three to push the matter with the county commissioners, the meeting adjourned.—Zina Pitcher, M.D., Secretary.

Medina County Medical Society met Thursday, February 28, in the board of health rooms, at Medina. Robert W. Depuy, county relief director, was the speaker.—News Clipping.

Sixth District

Mahoning County Medical Society, at its meeting on Tuesday evening, March 19, had as guest speaker, Dr. R. H. Jaffe, director of laboratories, Cook County Hospital and professor of pathology, College of Medicine of Illinois, who spoke on "Malignancies of the Lung".—Bulletin.

Richland County Medical Society held its monthly meeting at the General Hospital, Mansfield, on Thursday afternoon, February 28. Dr. Gerald Shibley, professor of medicine, Western Reserve University, Cleveland, spoke on "The Common Cold". Following the program, a waffle supper was served by staff nurses of the hospital. —News Clipping.

Portage County Medical Society met at the home of Dr. S. A. Brown, in Kent, on Thursday evening, March 7. "Legislation at Columbus" was discussed by Dr. George J. Waggoner, of Ravenna, legislative committeeman of the society. An illustrated lecture on "Electrocardiography" was presented by Dr. S. Morgenroth of Akron.—Bulletin.

Summit County Medical Society held its regular meeting on Tuesday evening, March 5, at the Mayflower Hotel, Akron. Guest speaker for the meeting was Dr. Wells Teachnor, Sr., of Columbus, who discussed "The Diagnosis of Cancer of the Rectum and Colon".—Bulletin.

Seventh District

Columbiana County Medical Society met in Lisbon on Tuesday afternoon, February 19, for its regular monthly meeting. Dr. E. R. Thomas, Youngstown, addressed the society on "Accidents to the Newborn". Dr. C. W. Kirkland, Bellaire, councilor of the Seventh District, was present.—Guy E. Byers, M.D., Secretary.

Coshocton County Medical Society, met on Thursday evening, February 28, at the City Hospital, Coshocton. Dr. L. D. Lebold, Warsaw, gave a case report on "Exophthalmic Goiter", and Dr. W. F. Lyons discussed "Erysipeloid, the Human Disease Caused by Handling Hogs Suffering from Swine Erysipelas".—News Clipping.

Jefferson County Medical Society met in joint session with the staff of Ohio Valley Hospital, Steubenville, at the hospital, on Tuesday evening, February 19. An address on "Cancer", by Dr. A. E. Weinstein, was illustrated with motion pictures. Plans were discussed for the society's

work during the year and a program committee appointed, consisting of Dr. Weinstein. Dr. Howard Brettell, and Dr. C. W. Sunseri.—News Clipping.

Tuscarawas County Medical Society held its regular meeting on Thursday night, February 14, in the council chamber, New Philadelphia. "The Diagnosis and Pathology of Appendicitis and Complicating Peritonitis", was the subject of a paper presented by Dr. K. E. Shaweker. "The Operative Treatment of Appendicitis and Complicating Peritonitis" was covered in an address by Dr. D. W. Shumaker. Discussion was opened by Drs. Coleman, Bennett and Wolfe.—Bulletin.

Eighth District

Athens County Medical Society met at the Christian Church in Athens on Monday, March 4, for a luncheon meeting. Dr. S. D. Edelman, of Columbus, spoke on "Infant Feeding".—News Clipping.

Guernsey County Medical Society held a joint meeting with the dentists of the county, on Thursday afternoon, February 21, at the Berwick Hotel, Cambridge. No formal program was given, but the time was spent in informal discussion following the luncheon.—News Clipping.

Muskingum County Academy of Medicine held its March meeting in the University Club rooms, Zanesville, on Wednesday evening, March 6. Dr. A. C. Ormond, of Byesville, read a paper on "Spinal Anesthesia". Luncheon was served after the meeting.—Bulletin.

Washington County Medical Society met Wednesday evening, February 13, at the Marietta Memorial Hospital. A paper on "Spinal Anesthesia" was presented by Dr. Paul D. Scofield, of Columbus.—News Clipping.

Ninth District

Hocking County Medical Society held its regular monthly meeting Thursday noon, February 14, at the Easterling Club, Logan. Following a dinner, Dr. Allan A. Cole, of Logan, addressed the Society.—News Clipping.

Scioto County—Regular meeting of the Hempstead Academy of Medicine was held on Monday evening, March 11 at Recreational Hall, Nurses Home, Portsmouth. C. M. Searle, attorney, Portsmouth, addressed the members on "Medico-Legal Matters". Buffet lunch was served following the meeting.—Bulletin.

Vinton County Medical Society has elected Dr. O. S. Cox, of McArthur as president. Other officers are, H. D. Chamberlain, secretary-treasurer and correspondent for *The Journal;* Dr. A. A. Boal, legislative committeeman, and Dr. W. R. L. Dwyer, New Plymouth, medical defense committeeman.

Tenth District

COLUMBUS ACADEMY OF MEDICINE

(Drew L. Davies, M.D., Secretary)

March meetings of the Academy were as follows:

March 4—"A Practical Method of Thinking About Nephritis", Dr. A. Graeme Mitchell, Cincinnati.

March 11—Symposium on Obstetrics: "Dystocias of the Pelvis", Dr. W. D. Inglis; "Some Abdominal Conditions Developing in the Third Trimester of Pregnancy", Dr. Andrews Rogers; "Puerperal Sepsis", Dr. S. J. Goodman; "The Relationship Between Gynecology and Obstetrics", Dr. Roy E. Krigbaum. Discussions by Dr. H. W. Koerper and Dr. Charles E. Turner.

March 18—"Female Sex Hormones", (illustrated with lantern slides) Dr. Edwin J. Stedem. Discussions by Dr. George M. Curtis and Dr. R. S. Fidler.

March 25—General Practitioners Section: "The Physician and His Drugs", Paul Nicholas Leech, Ph.D., Secretary, Council on Pharmacy and Chemistry, American Medical Association, Chicago.

Crawford County Medical Society met Monday evening, March 4, at Bucyrus City Hospital. "Allergy in General Practice" was discussed by Dr. Jonathan Forman, Columbus, lecturer on diseases due to allergy, at the Ohio State University College of Medicine. Dr. Frank T. Gallen, Columbus, spoke on "The Skin Manifestations of Allergy".—Bulletin.

HOSPITAL NOTES

—Review of activities of Jewish Hospital Cincinnati, revealed a marked increase of admissions in 1934 over the percentage of occupancy in 1933. Several new medical services were inaugurated during the year.

—Announcement has been made of the appointment of Dr. John G. Fleming as resident of surgery, and Dr. Stanley Weinstein as resident in medicine at Deaconess Hospital, Cincinnati. The following new internes were appointed, effective July 1: Donald R. Sperry; Julius L. Boraisky, James M. Coram, and Robert E. Schettler.

—Fosteria City hospital has employed laboratory and *X*-ray technicians, following action of City Council in appropriating a sum not to exceed $3,000, based on a fee system.

—Board of trustees of Robinson Memorial hospital, Ravenna, celebrated the third anniversary of the opening of the hospital, recently.

Deaths in Ohio

C. F. Adams, M.D., Springfield; Medical College of Ohio, Cincinnati, 1884; aged 74; member of the Ohio State Medical Association and the American Medical Association; died February 15 of heart disease. Dr. Adams, in active practice for more than 50 years, located in Sabina, following his graduation, and for the past 28 years practiced in Springfield. He served as physician at the I. O. O. F. Home, Springfield, for 20 years. Surviving are his widow and one sister.

Robert G. Anderson, M.D., Elyria; Medical Faculty of Trinity University, Toronto, Canada, 1895; aged 69; former member of the Ohio State Medical Association; died March 3. Dr. Anderson had practiced in Elyria for 40 years.

A. S. Beckwith, London; licensed 1896; aged 77; died February 20. His widow and one daughter survive him.

Frederick H. Brumm, M.D., Coldwater; Medical College of Ohio, Cincinnati, 1907; aged 49; member of the Ohio State Medical Association and the American Medical Association; died February 10 of heart disease. Dr. Brumm, son of the late Dr. Lewis D. and Mrs. Hannah Brumm, of Celina, had practiced in Coldwater for the past 27 years. He is survived by his widow, two sons, his mother, one brother and one sister.

Ellis Corwin Cope, M.D., Barton; Ohio Medical University, Columbus, 1893; aged 66; member of the Ohio State Medical Association and Fellow of the American Medical Association; died February 13. Dr. Cope, son of the late Dr. Isaac and Elizabeth Cope, was the fourth generation of his family who practiced medicine. He had practiced in Belmont county for 42 years. He was a Mason, Knight Templar, and Knight of the Mystic Shrine. Surviving him are his widow, one daughter, one son, Dr. Ellis P. Cope, of Barton, and three sisters and brothers.

James T. Gibson, M.D., Lynchburg; Medical College of Ohio, Cincinnati, 1897, aged 67; member of the Ohio State Medical Association and Fellow of the American Medical Association; died suddenly of a heart attack on February 14. Immediately following graduation he began practice in Lynchburg. He was a member of the local board of education, member of the Presbyterian church, and a Mason. He is survived by his widow, one son, one daughter, and one brother.

Cephas C. Greiner, M.D., Pemberville; Physio-Medical Institute, Cincinnati, 1896; aged 72; member of the Ohio State Medical Association and the American Medical Association; died February 23, in Community hospital, Fremont, as the result of injuries received in an automobile accident. Dr. Greiner had practiced in Pemberville for 37 years, and was active in community affairs. He was a member of the Masonic lodge. Surviving him are his widow, two sons, a daughter, a sister and a brother.

James Howard Harris, M.D., Clifton; Starling Medical College, Columbus, 1895; aged 62; member of the Ohio State Medical Association, and Fellow of the American Medical Association; died suddenly March 2, of angina pectoris. Dr. Harris had practiced in Greene and Clark counties for 40 years, and for several years maintained offices both at Clifton and Springfield. Besides his widow, one son survives.

George Hartnagel, M.D., Delphos; Northwestern University Medical School, Chicago, 1910; aged 55; member of the Ohio State Medical Association and the American Medical Association; died February 8 of coronory thrombosis. Dr. Hartnagel had practiced in Delphos and Allen county since his graduation. He was a member of the Catholic church, and of the Catholic Knights of Ohio and the Eagles lodge. During the World War, he served in Army hospitals at Camp Greenleaf, Georgia, and Carlisle, Pennsylvania. Surviving him are his widow, one daughter, four brothers and three sisters.

John Ross Jameson, M.D., Wooster; Medico-Chirurgical College of Philadelphia, 1894; aged 70; member of the Ohio State Medical Association and Fellow of the American Medical Association; died February 28, following an illness of several weeks. Dr. Jameson served his internship at Philadelphia, following which he returned to Applecreek where he practiced until moving to Wooster fifteen years ago. He was president of the Applecreek Banking Company, and a director in the Peoples Savings and Loan Company of Wooster. Dr. Jameson was an elder in the Presbyterian church and a member of Beta Theta Pi. He is survived by his widow, two sons and two daughters.

Albert L. Kiraly, M.D., Cleveland; Eclectic Medical College of the City of New York, 1902; aged 59; died February 7. Dr. Kiraly had practiced in Cleveland for many years and was a leader in the city's Hungarian community. He is survived by his widow and two sons.

Glenn Longnecker, M.D., Washington C. H.;

Eclectic Medical College, Cincinnati, 1922; aged 33; died at the National Military Home, Dayton, February 20.

Elmer I. McKesson, M.D., Toledo; Rush Medical College, University of Chicago, 1906; aged 54; member of the Ohio State Medical Association, Fellow of the American Medical Association; Fellow of the American Association of Anesthesists; and an active or honorory member of a number of professional groups in this and foreign countries; died February 22. Dr. McKesson came to Toledo Hospital as interne. At the end of that period he became secretary and associate professor of physiology and physiological chemistry of old Toledo Medical College. As an inventor and manufacturer, Dr. McKesson gave to modern medicine the tools and technique of gas-oxygen anesthesia, surgical pumps, metabolism and vital capacity testing equipment and the hydrophorograph. He made the first artificial larynx, which restored the power of speech. Dr. McKesson was a former president and trustee of the Academy of Medicine of Toledo; director of anesthesia at Lucas County, St. Vincent's and Toledo State hospitals and consulting anesthetist at Toledo and Flower hospitals. He was a 32nd degree Mason and a member of St. Paul's M. E. Church. Surviving him are his widow, one son, and two sisters.

Charles Clyde McLean, M.D., Dayton; Medical College of Ohio, Cincinnati, 1895; aged 63; member of the Ohio State Medical Association and the American Medical Association; died March 13 of a cerebral hemorrhage. Dr. McLean was in general practice of medicine in Dayton for 25 years before he became head anesthetist at St. Elizabeth Hospital in 1900, a position he retained until his death. Dr. McLean was a past president of the Montgomery County Medical Society, and for many years represented that society as delegate to the Ohio State Medical Association. He was a member and past president of the Mid-Western Anesthetists Association, a member of the Associated Anesthetists of the United States and Canada, and a member of the Board of Directors of the International Anesthetists Research Bureau. He was a thirty-second degree Mason. Besides his widow, he is survived by one son, one daughter, and a sister.

William Sheffield Powell, M.D., Defiance; Jefferson Medical College of Philadelphia, 1874; aged 84; member of the Ohio State Medical Association and Fellow of the American Medical Association; died March 3 from shock suffered in a fractured hip. Dr. Powell began practice with his brother, the late Dr. H. B. Powell, at Napoleon, and in 1876 he moved to Defiance where he continued in active practice. He was a member of the Masonic order and charter member of Defiance Commandery of Knights Templar, and the Defiance Rotary Club. Two daughters survive him.

John Shank, M.D., Trotwood; George Washington University, Washington, D. C., 1934; aged 26; died February 20. Dr. Shank, son of the late Dr. R. R. Shank, of Trotwood, had been serving his internship at Miami Valley hospital. He was a member of Delta Kappa Epsilon and Phi Chi fraternities. Surviving him are his mother, and two sisters.

Otto Carl Stutz, M.D., Upper Sandusky; Cleveland College of Physicians and Surgeons, Cleveland, 1885; aged 71; member of the Ohio State Medical Association and the American Medical Association; died February 28. Dr. Stutz had practiced in Upper Sandusky for nearly 50 years. For several years he served on the board of pension examiners, and as assistant surgeon, in the Ohio National Guard, Second Regiment. He was a member of Trinity Reformed church and several local fraternities. Surviving him are his widow, one son, two brothers and four sisters.

Jonathan B. Vail, M.D., Lima; Medical College of Ohio, Cincinnati, 1871; aged 90; member of the Ohio State Medical Association and the American Medical Association, died February 14. Dr. Vail had practiced in Allen County for nearly 60 years. For a number of years he was located in Kalida, and served that city as mayor for two years. He was a former president, and honorary member of the Allen County Medical Society, former city health officer and member of the school board of Lima, and member of the board of pension examiners for Allen county. In 1911 he was elected trustee of Miami University. Dr. Vail was a Mason and an Elk, and a Veteran of the Civil War. One son and two daughters survive him.

Delphus B. Virtue, M.D., Mansfield; Starling Medical College, Columbus, 1891; aged 69; former member of the Ohio State Medical Association; died February 26 of angina pectoris. Dr. Virtue practiced at Iberia, Morrow county, for twenty years. During the World War, Dr. Virtue served at army hospitals at Fort Thomas, New Orleans, and Alexandria, La. He continued in Army service until his retirement, with the rank of Major, in 1933. Dr. Virtue was a member of the Presbyterian church, the Masonic lodge, Knights of Pythias, and the American Legion. Surviving him are his widow, five sons and one daughter.

KNOWN IN OHIO

Alexander Pollock, M.D., Addis Ababa, Abyssinia; University of Pittsburgh School of Medicine, 1901; aged 60; died in February. Dr. Pollock had spent the last 30 years as a medical missionary in Egypt and Abyssinia.

MORE EXTENSIVE PRACTICE OF PREVENTIVE MEDICINE IS SUGGESTED AS A PARTIAL SOLUTION OF ECONOMIC PROBLEMS

The economic stress with which many physicians are now confronted has stimulated among the profession an unprecedented interest in the economic and social aspects of medical practice.

Physicians have begun to realize that the practice of medicine is vitally affected by social and economic developments and changes outside the field of medicine itself. They have not forgotten that altruism is still an essential element in medicine but they have learned from experience that altruism alone does not provide the necessities of life nor the means of meeting the costs of medical practice. They have learned that occasionally the physician must think in terms of dollars and cents.

As a result, the medical profession is taking stock of itself and analyzing the possibilities of the future. The question of income and economic security is one of the problems confronting the profession which cannot be sidestepped.

One possibility which may meet this problem to a considerable degree is the development on the part of the profession of new sources of revenue by broadening the field of private medical practice.

For example, it has been pointed out repeatedly by some thoughtful and forward-looking medical men that many physicians have ignored a lucrative source of income and overlooked an opportunity to increase their clientele by not including personal preventive medicine, including examination of the apparently well, as a part of their daily, routine practice.

Physicians generally have recognized the value of this phase of medicine and have found it to be of great benefit to the public when conducted along safe and sane lines and by qualified practitioners. However, only a comparatively few physicians have placed real emphasis on this type of service.

This is something which today merits the careful consideration of all physicians, not only from the standpoint of public benefit but from the standpoint of the physician himself.

Some of the enthusiastic supporters of the periodic health examination movement believe that some of the complex economic and social questions which confront the profession can be partially solved, at least, if the profession generally will take full advantage of this opportunity to meet the increasing demands of the public for counsel and examination by competent medical men before curative means are required.

An interesting slant on this subject was offered some time ago by Dr. A. J. Rongy, who at that time was chairman of the Greater New York Committee on Health Examinations.

Writing in a bulletin issued by his committee, Dr. Rongy made the following comments, some of which are debatable but none-the-less thought-provoking:

"Economic upheavals bring about vital changes in the social structure. Industry, finance, and labor have to be carefully and intelligently adjusted. In each field of human endeavor new problems arise, which must be correctly evaluated and appraised if society is to continue to function properly.

"The practice of medicine is no exception to the general rule. Here, also, a readjustment should take place. The methods of medical practice, which obtained during an era of prosperity, can no longer continue. The lavish expenditures, which prevailed in the treatment of the sick, will no more be possible. This readjustment of methods as well as the manner of medical care is the order of the day. It should be accomplished intelligently with equity to all concerned.

"How may this be accomplished? How shall the Medical profession proceed to bring about the necessary changes, which would result in the greatest benefit to both patient and doctor? It seems that the problem resolves itself into two distinct propositions: 1) affecting the individual physician, 2) affecting the collective action of the medical profession.

"It is generally admitted that the family physician is the pivotal figure in the scheme of the practice of medicine. It is he who is the functional unit of the medical profession. His position must be economically sound, otherwise the health of the community will be endangered. The family physician must not be allowed to find himself in a situation, which would compel him to deviate from normal and legitimate channels of practice. He must not be forced, because of economic necessity to abandon medicine or to stoop to irregular practice.

"Thoughtful people frequently ask whether the hardships and the difficulties, that many of the family physicians are undergoing now, are not in part at least of their own making. Has the family doctor really intelligently utilized all the opportunities afforded him to gain a decent livelihood, or did he neglect or abondon legitimate sources of income, which properly belong to him?

"In recent years, the practice of medicine, not unlike finance and industry, became a bit frenzied. The family doctor, too, lost his equilibrium, consciously or unconsciously, he pursued methods in his practice, which reacted unfavorably on his medical position as well as on his reputation. The family doctor, instead of being the master in the sick chamber and assuming full responsibility for the case and the treatment of the patient, has permitted himself to be relegated to an inferior position, which is not at all in consonance with the dignity of his calling. What are some of the defects in the prevailing methods of the practice of medicine? How can the family doctor enhance his

economic security? I shall cite only a few instances at this time.

"The family doctor, to a large degree, is responsible for the tremendous and very often unnecessary hospitalization of patients throughout the country. Of course, in many instances he is not to be blamed for it, he is often forced to do it in order to maintain his position on the hospital staff. Many a patient, who could just as easily be cared for at home, is sent to the hospital. This generally proves costly to the patient. Any additional expense that a patient has to incur must necessarily affect the medical fee. The doctor's bill receives last consideration, and very often the patient's resources are so depleted by the hospital charges that he is unable to meet his obligation to the physician. The majority of patients, who suffer from uncomplicated medical conditions, do not require hospital attention. They could be and should be treated at home. This would help to reduce the cost of medical care and the patient would be in a better position to meet the medical fee. Furthermore, it would help to re-establish the old relationship between doctor and patient, and the family doctor would once again be in a position of dignity.

"During a prosperous period it was inevitable that specialization, as we now know it, should grow to disproportionate prevalence. The function of the family doctor became so reduced that he practically became a referring agent for the specialists. His sphere of usefulness became so circumscribed that his opinion was not given serious consideration by the patient. Under such circumstances medical service became too costly. It came to pass that patients ceased to consult the family doctor whenever they required special medical service, and consulted the specialists directly. The family doctor, who knew the circumstances surrounding the case, was not given the opportunity to guide either the patient or the specialist.

"There was a time when the family doctor was less equipped to practice medicine, and he practiced his profession more broadly than does the modern highly trained young doctor. Nowadays the family doctor is unwilling to treat simple medical or surgical conditions, which he is perfectly competent to do. Is there any reason why the general practitioner should not remove a cyst of the scalp, cauterize an infected cervix, remove a simple nasal polyp or a skin epithelioma? There are many minor surgical conditions, which properly belong in the domain of general practice of medicine. The family doctor is definitely responsible for this diversion of patients from his office. He eventually loses not only his patients, but also their friends, who are potential patients. Specialism, properly linked to the general practice of medicine, is beneficial both to patient and doctor; superspecialism is a canker sore, engrafted, a monstrosity created by and with the help of the family doctor, to the detriment of the public and the medical profession.

"Personal preventive medicine has now a definite place in the scheme of medical practice. Periodic health examination of the healthy has proved to be beneficial beyond any shadow of doubt. The reports of large insurance companies and industrial organizations claim favorable gains in the health of large groups, where these examinations have been intelligently carried on.

"The family doctor has been entirely remiss in this important phase of medical practice. Odd as it may seem, it is the laity who first appreciated and instituted these examinations. It is they who forced the issue on the medical profession. Isn't it logical to assume that the physician should have been primarily responsible for initiating the practice of health examinations? Who but the physician can best disseminate the idea among the public? No physician is so preoccupied that he could not spare the time or acquire the necessary technique to make a routine health examination. Every doctor could easily set apart one or two afternoons a week for this work. A sign in the waiting room informing the patients that at a given hour he will devote himself to health examinations only, would in many instances be the starting point for a lucrative and beneficial practice.

"It seems to me that the time is now ripe for the physicians to begin to consider seriously the question of personal preventive medicine. The value of such examinations must be emphasized more and more to the public. Such a campaign of education will begin to bear fruit when economic recovery takes place. At that time both the medical profession and the public will be ready to utilize one of the most beneficial procedures yet to be found within the entire range of medical practice.

"A hospital intern spends at least four to six months in the clinical laboratory. He receives an intensive training in the ordinary laboratory methods. He is taught to examine blood and urine, and gains a fair knowledge of bacteriology; in short, he becomes fully equipped to make all the tests that are necessary to supplement clinical diagnosis. It is curious, however, how quickly the average hospital graduate discards his laboratory knowledge and begins to travel along the road of least resistance by referring patients to commercial laboratories for the most simple blood and urine examinations. Young physicians would add a great deal to their prestige and reputations by demonstrating to their patients that they are even capable of performing some of the more refined examinations. Extra medical work has its cumulative effects and eventually the doctor would gain by it if his charges were modest.

"The average doctor is not resourceful. He fails to utilize all the legitimate avenues of income. He often undermines his economic position by refusing to apply his knowledge and skill whenever the opportunity presents itself. The successful physician is the one, who constantly increases his field of usefulness in the treatment of his patients.

"Organized medicine, from time to time, guided the individual physician and indicated to him what course to pursue in the practice of his profession. It consistently tried to safeguard, although not always successfully, the interest of the physician. It always managed to steer the ship of medicine through troublesome seas. Organized medicine would have accomplished more, if the rank and file were not so nonchalant and lethargic about many problems that are important and vital to their existence. For many years, organized medicine, here and elsewhere, diligently tried to point out to physicians, especially to the family doctor, that the time has come for them to give serious thought to the practice of preventive medicine; that for the good of the public and the physicians periodic health examination must become an integral part of the practice of medicine. The response, however, of the average doctor to those exhortations, has been disappointing. It is only through the zealousness of a small group of doctors and a few intelligent laymen in every section of the country in spreading the gospel of

preventive medicine, that any progress in this direction has been made.

"It seems logical to assume that when organized medicine, after due deliberation, arrived at the conclusion that, in the interest of personal preventive medicine, it would urge every physician to advise his patients to have periodic health examinations, each and every physician would grasp the opportunity and immediately take the necessary steps to carry this idea into practice. Why are the physicians so tardy in accepting innovations? Is it mere inertia on their part, that something of which the medical profession has been guilty throughout its history?

"The difficulties that are now facing the profession are partly of its own creation. No matter what phase of medical extravagance one may turn to he will find that it is in part due to the fact that the physicians did not anticipate the demands of a highly organized social organism. This is true in both the field of curative and preventive medicine. This very often was the cause of friction and misunderstanding between the physicians and the public. The time is now propitious to correct many evils and abuses that have crept into the practice of medicine. When spiritual values are better appreciated, when less emphasis is being placed upon wealth, it is opportune to set the medical house in order.

"The family doctor must call a halt on all unnecessary and superfluous specialistic expenditures; instead, he should try to broaden his sphere of medical practice. This will help to reduce the cost of medical care. It will tend to stabilize the practice of medicine. The problem of the cost of medical care must be solved by and through the medical profession. It can be accomplished if the individual physician will become more conscious of his function as the guardian of the health of the community.

"The physicians individually and collectively must see to it that the practice of medicine is organized on a basis, which will redound to the best interest of the public and the medical profession."

—OSMJ—

Ohio to Seek $15,000,000 From U. S. For State Welfare Building Program

Mrs. Margaret Allaman, State Welfare Director, has announced that Ohio would seek $15,000,000 from the Federal Government under the pending U. S. relief proposal for a state welfare institutional building program.

Of the amount, the state would use $900,000 for the purchase of land and the balance for the improvement of existing welfare institutions and new construction.

The project, including land purchases, as listed by the State Welfare Department are as follows:

Institution of epileptics (Central Ohio), $2,500,000, of which $300,000 is for purchase of land.

Hospital for mentally sick, $2,500,000, of which $300,000 is for land purchase.

Penal institution for segregation of prisoners, $3,000,000, of which $250,000 is for land.

Institution for feeble-minded (Apple Creek), $2,000,000, including administration building, four cottages, dining room, kitchen, and cold storage, extension of pipe line and tunnel and sewage disposal plant.

Cleveland State Hospital, $350,000, including two cottages and tuberculosis building; Hawthornden Farm, $750,000, including four cottages and administration building.

Longview State Hospital, Cincinnati, $500,000, including two cottages, dining room, kitchen, and cold storage and third-floor receiving cottage.

Dayton State Hospital, $200,000, including two cottages, fireproofing main building and new boiler equipment.

Lima State Hospital, Lima, $150,000, including third floor of main building, extension of service lines, steam and electric improvements.

PUBLIC HEALTH NOTES

—County Commissioners of Delaware County have under consideration a plan for the erection of a tuberculosis wing to the Jane M. Case Hospital, Delaware.

—Dr. I. C. Riggin, former health commissioner of Lorain County and former executive director of the American Heart Association, has been appointed state health commissioner of Virginia, succeeding Dr. W. F. Draper who has resumed his duties with the U. S. Public Health Service.

—Dr. James A. Doull, professor of hygiene and public health, Western Reserve University, has been elected an honorary member in the Royal Sanitary Institute of Great Britain.

—Dr. Robert P. Bogniard has been named health commissioner of Ashland, succeeding Dr. George W. Mehl, resigned because of illness.

—Dr. W. A. Holman, London, has been elected president of the Madison County Board of Health.

—Dr. Albert J. Michels has been elected president of the staff of the East Liverpool City Hospital; Dr. J. S. McCulloch, vice president; Dr. J. A. Fraser, secretary-treasurer, and Dr. W. A. Hobbs and Dr. C. H. Bailey, trustees.

—OSMJ—

The Eleventh Scientific Session of the American Heart Association will be held on Tuesday, June 11, 1935, at the Hotel Claridge, Atlantic City. Program will be devoted to various subjects on cardiovascular disease.

—OSMJ—

A chapter of Nu Sigma Nu, national medical fraternity, has been installed at Ohio State University by absorbing the local medical fraternity of Alpha Mu Pi Omega, in existence at Ohio State since 1900.

American Medical Golfers to Play In Atlantic City, June 10

The American Medical Golfing Association will hold its twenty-first annual tournament at the Northfield Country Club in Atlantic City on Monday, June 10, 1935.

Thirty-six holes of golf will be played in competition for the seventy trophies and prizes in the nine events. Trophies will be awarded for the Association Championship, thirty-six holes gross; The Will Walter Trophy; the Association Handicap Championship, thirty-six holes net, The Detroit Trophy; the Championship Flight, First Gross, thirty-six holes, The St. Louis Trophy; the Championship Flight, First Net, thirty-six holes, The President's Trophy; the Eighteen Hole Championship, The Golden State Trophy; the Eighteen Hole Handicap Championship, The Ben Thomas Trophy; the Maturity Event, limited to Fellows over 60 years of age, The Minneapolis Trophy; the Oldguard Championship, limited to competition of past presidents, The Wendell Phillips Trophy; and the Kickers Handicap, The Wisconsin Trophy. Other events and prizes will be announced at the first tee.

Dr. Charles Lukens of Toledo is president and Dr. C. H. Henninger of Pittsburgh and Dr. John B. Morgan of Cleveland are vice-presidents of the American Medical Golfing Association, which was organized in 1915 by Dr. Will Walter, Dr. Wendell Phillips and Dr. Gene Lewis, and now totals 1,100 members representing every state in the union.

The Atlantic City Committee is under the chairmanship of Dr. Walt P. Conaway, 1723 Pacific Ave., Atlantic City. He will be assisted by Drs. I. R. Beir, John Pennington, Alfred Westney, and Rostin White.

The Northfield Country Club of Atlantic City is described by Chairman Conaway as "certainly one of the most interesting courses in this district. Many championships have been held at Northfield, and I am sure the visiting doctors will be delighted with it in every sense of the word. It has a beautiful club house with every facility ready for the pleasure of the guest".

All male Fellows of the American Medical Association are eligible and cordially invited to become members of the A.M.G.A. Write the Executive Secretary, Bill Burns, 4421 Woodward Avenue, Detroit, for an application blank. Participants in the A.M.G.A. tournament are required to furnish their home club handicap, signed by the secretary. No handicap over 25 is allowed, except in the Kickers' (Blind Bogey). Only active members of the A.M.G.A. may compete for prizes. No trophy is awarded a Fellow who is absent from the annual dinner.

Much Progress Made in Sewage Treatment Plant Construction

The part that sewage treatment plays in eradicating stream pollution is well known. Consequently, progress made in the installation of municipal plants in Ohio in the past few years is gratifying. During the past five years 15 new plants have been placed in operation. These are listed below. It is worthy of note that, with two exceptions, these new plants are being operated under technical supervision. In addition to these 15 new plants, six existing plants have been improved either by rehabilitation or extension, or both. These six plants also are listed.

P. W. A. has been instrumental in furthering the campaign for improved sewage disposal. In the period of a little over a year that P. W. A. has been functioning, a number of sewage treatment projects have been inaugurated and today 11 new plants are under contract. With the completion of these plants a total of 26 new plants will have been placed in operation since 1929.

In addition to the foregoing, three projects for new sewage treatment plants have been approved by P. W. A. and await only the completion of engineering and financial details. These projects are at Byesville (pop. 2638), Wauseon (pop. 2889) and Willard (pop. 4514). In the case of Willard, a special election was held January 22, 1935, on the question of issuing bonds totaling $75,000 to pay part of the cost, the remaining cost, less the Federal grant, to be financed by mortgage revenue bonds in the amount of $62,000. The bond issue was approved by a vote of 767 yes to 284 no.

With the contemplated inauguration of a new works relief program by the Federal government it is most likely that a number of other Ohio municipalities will embrace the opportunity to construct much-needed sewage treatment projects.

The lists of plants completed and under construction follows:

NEW PLANTS IN PAST FIVE YEARS

Municipality	Pop. (1930)	Municipality	Pop. (1930)
Alliance	23,047	Madison	926
Dayton	200,982	Medina	4,071
Delphos	5,672	New Bremen	1,485
Elyria	25,633	New Lexington	3,901
Findlay	19,363	Norwalk	7,776
Hubbard	4,080	Toledo	290,718
Russells Point	5,000	West Jefferson	1,376
Lima	42,287		

PLANTS REHABILITATED IN PAST FIVE YEARS

Municipality	Pop. (1930)	Municipality	Pop. (1930)
Cleveland Westerly	900,429	Mt. Healthy	3,530
Columbiana	2,485	Orrville	4,427
Jackson	5,922	Bellefontaine	9,541

PLANTS UNDER CONSTRUCTION

Ashville	1,085	McArthur	1,188
Bowling Green	6,688	Shelby	6,198
Cleveland Easterly	900,429	Springfield	68,743
Columbus	290,564	Van Wert	8,472
Glendale	2,360	Washington C. H.	8,426
Hicksville	2,445		

—Ohio Health News.

NEWS NOTES of OHIO

Canton—Dr. Morris Fishbein, Chicago, editor of *The Journal, A. M. A.*, recently spoke here on "Frontiers of Medicine" before patrons of the Jewish Center Lecture Course. A dinner in his honor was attended by physicians from Stark and adjoining counties.

Columbus—Dr. F. F. Lawrence was honored at a banquet in recognition of his 50 years of service as a surgeon. Speakers included, Dr. C. D. Hoy, general chairman and toastmaster; Mr. Kenneth D. Tooill, managing editor, *Ohio State Journal;* Dr. Verne Dodd, who spoke on "Dr. Lawrence, the Surgeon"; Rev. Frank Fowler, who spoke on "Appreciation from the White Cross Hospital Staff", and Dr. Lawrence.

Dayton—Dr. G. C. Gilfillen addressed members of the Mercator Club on the subject of "Family Adjustments".

Painesville—Dr. G. O. Hedlund was elected president of the staff of Lake County Memorial Hospital. Other officers are Dr. W. R. Carle, of Perry, vice president, and Dr. J. Wertheimer, of Fairport, secretary.

Marion—Dr. H. O. Bratton, Columbus, was guest speaker at a recent meeting of the Pan-American Medical Association at Hotel Harding.

Freeport—Dr. F. Foster Dye recently opened an office here after serving his internship at Atlantic City Hospital.

Grove City—Dr. Arthur Hopwood, assistant chief physician of the Orient Hospital for Feeble Minded, gave a talk before the Men's League of St. John's Lutheran Church.

Chillicothe—Dr. Harold Crumley, formerly of Pomeroy, has taken over the office of the late Dr. Samuel M. Sproat.

Delphos—Dr. Howard Illig, former house physician at St. Rita's hospital, Lima, has leased the offices of the late Dr. George Hartnagel.

St. Marys—Dr. Guy Noble spoke on "Progress of Medicine and Surgery since the Time of Christ" at a recent meeting of the United Brethren Church Brotherhood.

Marion—Dr. Kenneth Smith gave a talk on "Pre-Natal Care" as the first of a series of lectures sponsored by members of the Epsilon Circle, Child Conservation League.

Burton—Dr. William A. Reed, formerly of Cleveland, has located here.

Lorain—Dr. S. V. Burley spoke before the home nursing and child care class of the Lorain Institute of Arts and Sciences. His topic was "The Eye, Ear, Nose and Throat."

Lancaster—Dr. Frederick James spoke recently before the Fairfield County Ministerial Association on "The Underprivileged Child".

Cincinnati—Dr. Louis G. Herrmann, assistant professor of surgery, Cincinnati General Hospital, discussed "The Diagnosis and Treatment of the More Common Types of Obliterative Arterial Diseases of the Extremities", at a meeting of the Ohio County (West Virginia) Medical Society.

Galion—Dr. Carl W. Sawyer, of Marion, was guest speaker for the annual Citizenship Banquet of the Women's Federation of Clubs of Galion.

New Philadelphia—Dr. J. M. Smith recently celebrated his 79th birthday and his 56th year of active medical practice.

Painesville—Dr. E. L. Haffner, of Fairport, has been reappointed county physician.

Batavia—Dr. William E. Thompson, of near Bethel, who will celebrate his 100th birthday next June, recently completed his 75th year of active practice.

Cincinnati—Dr. Louis A. Lurie spoke before the American Orthopsychiatric Association in New York, recently.

Akron—The Doctors' Symphony Orchestra, organized in 1926, gave its 52nd concert at the Summer Home for the Aged, recently.

Hamilton—Dr. Simon H. Rosin, graduate of the University of Cincinnati Medical College, has located in this city, and will specialize in pediatrics.

Youngstown—Mahoning County Bar Association and the Mahoning County Medical Society held a "get-together" banquet on March 7. Plans for the program were arranged by Dr. D. H. Smeltzer and Dr. M. H. Bachman, and Mr. Russell Mock.

Carey—Announcement has been made of the marriage of Miss Dorothy Kemper, of Cincinnati and Dr. Robert J. Semons, of Carey, on February 25.

Toledo—Announcement has been made of the marriage on February 19 of Miss Mildred L. Mason, graduate nurse, and Dr. Charles A. Bayer, both of this city.

Cincinnati—Marriage of Miss Angelese Hays and Dr. R. L. Hilsinger, was announced on February 23.

Cincinnati—Dr. J. B. Hannah, of Addyston, recently completed 50 years of active practice.

Annual Intensive Post-Graduate Course for Doctors of Medicine

INDIANA UNIVERSITY SCHOOL OF MEDICINE

Announces the holding of its Post-Graduate Course from

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The first week is intensive, including a series of lectures, clinics and demonstrations, stressing diagnosis and newer methods of treatment. Symposia will be held on clinical disease entities and on symptoms.

Evening programs will consist of addresses by nationally known physicians from other states.

A second Optional week will be available in any of the branches of medicine and surgery and the specialties. This week gives special emphasis to bedside and laboratory study. For further details write the Registrar, of the Indiana University School of Medicine, Indianapolis, Indiana. A registration fee of $10.00 will be charged.

Approximately 3,000,000 School Children Have Defective Eyesight, Committee Finds After National Survey

Approximately 3,000,000 school children in the United States—one-eighth of the entire school population—are handicapped in their education by defective eyesight, it is disclosed in the report of a Joint Committee of the National Education Association and the American Medical Association cooperating with the National Society for the Prevention of Blindness, 50 West 50th Street, New York City.

Farsightedness is the most common visual defect among American school children, according to the report, prepared under the direction of Dr. Thomas D. Wood of Columbia University and published by the National Society for the Prevention of Blindness with the title "Conserving the Sight of School Children." Astigmatism is next in frequency, and nearsightedness is third; other eye defects mentioned are cross-eyes and inflammation of the eyelid lining.

Although the report recommends that the school should assume the primary responsibility for giving adequate attention to the eye health of children, it urges parents to learn what the school is doing in sight conservation and how they may cooperate in the home. The report says, further, that "it is not necessary that the school should furnish all the service required in the discovery and correction of the visual defects of children. These services may be secured from professional health organizations, family physicians, community health centers or elsewhere.

"The importance of good eyesight among school children cannot be overestimated. We have come to recognize that defective vision or disease in the eyes of the child not only may have detrimental influence on his school progress, but may react upon his general health and upon his adjustment to his school, his playmates, and even to his family. This recognition has given new impetus to the work of discovering and correcting visual defects among children, beginning with the preschool age.

"The farsighted child is not usually discomforted by seeing at a distance. It is the close eye work that distresses him. The printed page which the normal eye reads without undue muscular strain at a distance of 14 inches may appear alternately blurred and clear to the farsighted child. If the farsightedness is pronounced, sustained effort at close work is maintained only at the cost to the child of headaches, nerve strain, fatigue, or vision that is definitely blurred. When the strain is more than he can endure and he sits back to look through the window at the distant hills, he is accused of lack of interest, lack of perseverance, and unwillingness to make an effort.

"To the nearsighted child, objects beyond a certain distance appear to be indistinct or hazy in outline, and if the child is very nearsighted he may even pass his playmates on the street without recognizing them. If the book is too large or too heavy to hold up to his face, he brings his head nearer to the page. Such a position is not only harmful to the eye and fatiguing to its muscles, but is also fatiguing to the muscles of the neck and shoulders. The near-sighted child has a tendency to go off by himself to read, not because he is unsociable, but because he can see to read, while he cannot see to play ball. He may succeed very well in academic work and have the reputa-

CLASSIFIED ADVERTISEMENTS

Rates for advertisements under this heading are 50 cents per line, payable in advance. Minimum charge of $1.00 for each insertion. Price covers the cost of remailing answers. Forms close 16th of the month preceding publication.

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tion of being a good student, but he may be doing this at the expense of his physical and emotional well-being."

Calling attention to the fact that children with cross-eyes often become extremely sensitive and self-conscious because of the jibes of playmates and the thoughtless remarks of adults, the report says: "The sense of inferiority so often developed in children with squint may breed undesirable personality traits and unhealthful mental attitudes toward life. It cannot be overstressed that the most satisfactory results are obtained when the child with squint—no matter how young—is placed under the care of an ophthalmologist as soon as the defect is recognized."

In its concluding chapter, the report urges particularly that the school's provision for eye health should include medical supervision and special educational facilities for "children with such serious eye difficulties that after everything possible has been done for them they either cannot see well enough to profit by the usual school equipment or may be harmed by so doing." The report continues: "Probably one in 500 of the school population comes under this classification. This group has been designated as 'partially seeing.' They carry on their close eye work in sight-saving classes under the direction of specially trained teachers, but join their normally seeing companions in those school activities that do not require close eye work.

"In addition to having optimum lighting and seating conditions, these children with seriously defective vision should be freed from the strain entailed by much writing in longhand. As early as possible they should be taught the touch system of typewriting, and it is obvious that the typewriter should be equipped with large type. It is important that the partially seeing child learn to gather information through his sense of hearing, and that he read only books printed in type that will cause no eye fatigue."

At the present time, 6,000 children are enrolled in the 458 sight-saving classes maintained by 145 communities, where the special educational facilities and teaching methods used are similar to those described in the report. Additional classes are needed, however, for about 44,000 other children, according to the National Society for the Prevention of Blindness.

—OSMJ—

Columbus—Dr. M. D. Godfrey addressed a dinner meeting of the Business and Professional Woman's Club recently.

Oak Harbor—Dr. William R. Gibson, of Columbus Grove, has taken over the practice of the late Dr. Ballou.

New Philadelphia—Dr. Mary Elizabeth Rowland, formerly of Cadiz, has opened offices in this city.

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Legal Decision on Question of Ownership of Roentgenograms

Some time ago *The Journal* published a brief account of a decision rendered in the Municipal Court of Dayton relative to who possesses the property rights to roentgenograms—the physician or patient.

In the columns of *The Journal of the American Medical Association* a more detailed discussion of the Dayton case was presented for the purpose of supplying the profession generally with additional information on this important and confused question. The *A. M. A. Journal's* statement on the Dayton decision was as follows:

Roentgenograms made for a physician or a dentist, to assist in diagnosis and treatment, are not chattels in the sense that they can be bought and sold but are a part of the records of the case. In the absence of an agreement to the contrary, they belong to the physician or the dentist. This is the gist of the decision of the Municipal Court of Dayton, Ohio, Irwin W. Rohlfs, acting judge, in *Leas* v. *Otto*, Aug. 4, 1932. The case is the third in which a trial court has held that a roentgenogram made for the purposes of diagnosis and treatment does not belong to the patient unless there is an express agreement to that effect. As far as is known, however, no appelate court of last resort has passed on the question.

The plaintiff in the present case, a dentist, advised that a roentgenogram be made of the teeth of the defendant's wife. This was done, and a charge of $10 was placed on the books. At a second visit, the dentist stated his diagnosis and advised as to the work that he recommended be done, and a charge of $5 was made for this service. The defendant decided not to have the proposed work done but he demanded that the roentgenogram be given to him. The dentist refused. The patient's husband paid the $5 charged for the diagnosis and advice but refused to pay for the taking of the roentgenogram. The dentist thereupon sued to recover the amount due. The facts were admitted, the only question being whether the dentist or his patient's husband, who was liable for the cost of dental services for the wife, owned the roentgenogram. Judgment was rendered in favor of the plaintiff-dentist (following an opinion that cannot be stated better than in the court's own words:

The determination of this question involves the question of whether the X-ray film is a chattel subject to be bought and sold on the same basis as any other chattel. The court is of the opinion that an *X-ray* film is not a chattel in the sense that it can be bought and sold.

When a dental surgeon or a physician makes an *X*-ray of a patient he is required to have certain equipment in his office and to that end he purchases the *X*-ray machine itself and in the making of an *X*-ray film for a patient he pays for the material that goes into the making of said *X*-ray film or picture, and when said film or picture is produced it becomes a part of the record of that particular case and a part of the equipment of his office; said *X*-ray film or picture is of service and value only to the dental surgeon or physician who has knowledge and training in diagnosing the particular case and is a part of the record of that particular case and of value in giving said dental surgeon or physician enlightenment in the treatment of said case.

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In this case there is no testimony that there was an express agreement to transfer ownership of the *X*-ray film from the plaintiff to the defendant. The plaintiff testified that it is customary that such films be retained by the person who has taken them. The court is of the opinion that the retention of said film by the person taking them is necessary as a part of his record concerning the case, retained on the same basis and on the same theory that a surgeon retains his temperature chart that he has made, or other record concerning the diagnosis or treatment of a case; and that as a matter of law it must be said that where *X*-ray pictures are taken under circumstances such as they were taken by the plaintiff in this case, there is no implied understanding to turn those films over to the patient.

The court is further of the opinion that the protection of the person taking said films depends largely on the proper preservation of the same and such films should remain with said dental surgeon or physician. The interpretation is the all-important thing in connection with an *X*-ray examination. The film itself is simply the basis of the interpretation.

Detroit Physician Compiles List of Books to Assist Doctor in His Reading

For the past three years, Dr. William J. Stapleton, Jr., Detroit, has compiled annually for the *Detroit Medical News*, official publication of the Wayne County (Detroit) Medical Society, a list of a hundred or so novels about physicians and books on various phrases of medicine, mostly non-scientific in nature, and on some of the historical highlights of medicine.

In a recent issue of the *Detroit Medical News*, Dr. Stapleton's most recent compilation of volumes which might interest a physician was published, which included the following; together with Dr. Stapleton's brief comments on each:

The Great Doctors, by Dr. Henry E. Siegrist, professor of the history of medicine, John Hopkins. Published by Norton & Company. From the first Gods of Medicine, Imhotep the Egyptian and the Greek Aesculapius, to Pasteur and Osler. The author tells the story of those who "have forged new weapons against sickness". It is an inspiring book.

Choosing a Wife and Other Essays, by E. S. Dru Drury, published by Lewis & Co., London, England. What is more important than a good wife for a doctor?

Idols and Invalids, by J. Kemble, published by H. K. Lewis, London. Studies in the private lives of several of the world's most remarkable historical personages.

The Little Doctor, by F. G. Layton, published by Blackwood, London. A novel depicting the life of a panel doctor in the poorest district of an English manufacturing town.

A History of Medicine, by Charles Singer, M.A., M.D. Introducing medical principles to students and pre-medical readers. Oxford University Press. The position that medical science has now assumed in the social polity demands that all educated men and women have some knowledge of the subject.

Lettsom: His Life and Descendants, by J. Johnson Abraham, published by Heineman, London.

The Gold Headed Cane, by W. Macmichael. A new edition of this celebrated history of a cane.

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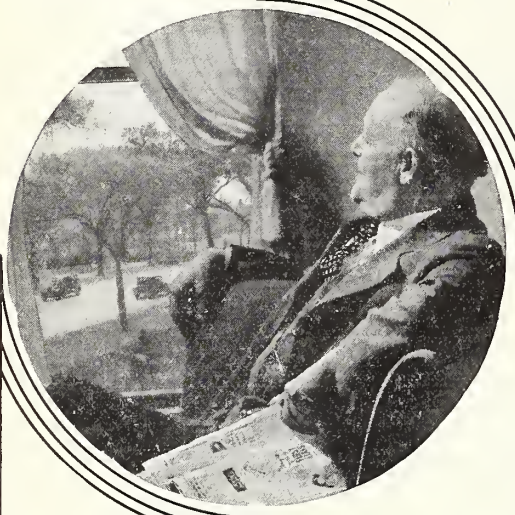
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Clinton	A. C. Roberts, Wilmington	V. E. Hutchens, Wilmington	1st Tuesday, monthly.
Fayette	J. M. Harsha, Washington C. H.	J. F. Wilson, Washington C. H.	1st Thursday, quarterly
Hamilton	John A. Caldwell, Cincinnati	H. J. Lavender, Cincinnati	Monday evening of each week.
Highland	H. H. Lowe, Leesburg	W. B. Roads, Hillsboro	1st Wednesday, monthly.
Warren	P. W. Tetrick, Mason	James Arnold, Lebanon	1st Tues. Apr., May, June, Sept., Oct., and Nov.
Second District			
Champaign	W. A. Yinger, Rosewood	F. E. Lowry, Urbana	2d Thursday, monthly.
Clark	C. S. Ramsey, Springfield	A. A. Gavey, Springfield	2d and 4th Thursday.
Darke	J. W. Van Lue, Gettysburg	W. D. Bishop, Greenville	3rd Friday, monthly.
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Miami	E. G. Puterbaugh, Tippecanoe City	G. A. Woodhouse, Pleasant Hill	1st Friday, monthly, except July and August.
Montgomery	A. G. Farmer, Dayton	Miss M. E. Jeffrey, Dayton	1st & 3rd Friday, Oct. to June
Preble	J. B. Lucas, West Alexandria	C. E. McKinley, Camden	3d Thursday, monthly.
Shelby	J. F. Conner, Sidney	W. J. Franke, Anna	1st Friday, monthly.
Third District			
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Auglaize	E. F. Heffner, Wapakoneta	C. C. Berlin, Wapakoneta	2nd Thursday, bi-monthly.
Hancock	H. O. Crosby, Findlay	R. S. Rilling, Findlay	1st Thursday, monthly.
Hardin	F. M. Elliott, Ada	W. N. Mundy, Forest	3d Thursday, monthly.
Logan	C. K. Startzman, Bellefontaine	M. L. Pratt, Bellefontaine	1st Friday, monthly.
Marion	J. A. Dodd, Marion	F. D. Yeager, Marion	1st Tuesday, monthly.
Mercer	L. M. Otis, Celina	F. E. Ayers, Celina	2d Thursday, monthly.
Seneca	W. W. Lucas, Tiffin	R. E. Hershberger, Tiffin	3rd Thursday, monthly.
Van Wert	B. L. Good, Van Wert	C. A. Morgan, Van Wert	1st Tuesday, monthly.
Wyandot	B. A. Moloney, Upper Sandusky	L. W. Naus, Upper Sandusky	1st Thursday, monthly.
Fourth District			
Defiance	P. B. Newcomb, Defiance	H. B. Wideman, Defiance	2nd Tuesday, Sept. to June
Fulton	C. F. Hartmann, Wauseon	Geo. McGuffin, Pettisville	3rd Thurs., monthly.
Henry	C. G. Hissong, Hamler	F. M. Harrison, Napoleon	2nd Tuesday, monthly.
Lucas	T. L. Ramsey, Toledo	F. C. Clifford, Toledo	Friday, each week.
Ottawa	L. L. Belt, Marblehead	Cyrus R. Wood, Port Clinton	2d Thursday, monthly.
Paulding	K. C. Evans, Payne	F. A. McCammon, Payne	3d Wednesday, monthly.
Putnam	C. W. Bird, Continental	L. M. Piatt, Ottawa	1st Tuesday, monthly.
Sandusky	A. F. Schultz, Fremont	C. J. Wolf, Fremont	Last Thursday, monthly.
Williams	E. R. Jacka, Bryan	H. R. Mayberry, Bryan	2nd Thursday, monthly, Sept. to June
Wood	F. L. Sterling, Bowling Green	R. N. Whitehead, Bowling Green	3d Thursday, monthly.
Fifth District			
Ashtabula	E. H. Merrell, Geneva	M. R. Martin, Geneva	2nd Tuesday, monthly.
Cuyahoga	Lester Taylor, Cleveland	J. A. Garvin, Cleveland	3d Fri. Feb., March, May, Sept., Nov., Dec.
Erie	L. S. Hill, Sandusky	R. M. Knoble, Sandusky	Last Thursday, monthly, except July, Aug.
Geauga	Lura E. Gordon, Burton	Isa Teed-Cramton, Burton	Last Wed. Apr. to Dec.
Huron	L. H. Hayhurst Greenwich	C. B. Thomas, Greenwich	Once monthly, Feb., May, Sept. & Dec.
Lake	C. H. Browning, Painesville	Mabel Pearce, Painesville	Last Tues., monthly.
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Ashland	L. G. Sheets, Ashland	M. J. Thomas, Jeromesville	2nd Friday, Sept. to May.
Holmes	Clyde Bahler, Walnut Creek	C. T. Bahler, Walnut Creek	1st Wed., Feb., Apr., June, Aug., Oct., Dec.
Mahoning	J. L. Fisher, Youngstown	W. M. Skipp, Youngstown	3d Tuesday, monthly.
Portage	A. M. Landsborough, Garrettsville	E. J. Widdecombe, Kent	1st Thursday, monthly.
Richland	B. E. Shreffler, Mansfield	H. C. Winbigler, Mansfield	Last Thursday, monthly.
Stark	M. E. Scott, Massillon	H. W. Beck, Canton	2d Tues., monthly, except July and Aug.
Summit	J. D. Smith, Akron	A. S. McCormick, Akron	1st Tuesday, monthly.
Wayne	W. A. Fritz, Wooster	R. C. Paul, Wooster	4th Friday, monthly.
Seventh District			
Belmont	W. L. Davis, Martins Ferry	C. W. Kirkland, Bellaire	1st Thurs., monthly, 4 p. m., except July and August.
Carroll	(With Stark Co. Society)		
Columbiana	F. R. Crowgey, Salem	G. E. Byers, Salem	2d Tuesday, monthly.
Coshocton	C. M. Neldon, Coshocton	J. D. Lower, Coshocton	4th Thurs., monthly.
Harrison	A. C. Grove, Jewett	W. C. Wallace, Hopedale	3d Wednesday, monthly.
Jefferson	H. H. Minor, Steubenville	J. Y. Bevan, Steubenville	3rd Tuesday, monthly
Monroe	G. W. Steward, Woodsfield	A. R. Burkhart, Woodsfield	2d Wednesday, monthly.
Tuscarawas	R. J. Foster, New Philadelpbia	C. M. Dougherty, New Phila.	2d Thursday, monthly.
Eighth District			
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Fairfield	K. W. Taylor, Pickerington	C. W. Brown, Lancaster	2d Tuesday, monthly.
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Licking	Geraldine Crocker, Granville	G. A. Gressle, Newark	Last Friday, monthly.
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Noble			
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Hocking	J. L. Webb, Nelsonville	M. H. Cherrington, Logan	2nd Thursday, monthly.
Jackson	J. S. Hunter, Jackson	J. J. McClung, Jackson	2nd Tuesday, monthly.
Lawrence	R. F. Massie, Ironton	W. W. Lynd, Ironton	1st Thursday, monthly.
Meigs	H. M. Crumley, Pomeroy	R. E. Boice, Middleport	3d Thursday, bi-monthly.
Pike	L. E. Wills, Waverly	R. T. Leever, Waverly	1st Monday, monthly.
Scioto	R. P. Elder, Portsmoutb	Wm. E. Scaggs, Portsmouth	2d Monday, monthly.
Vinton	O. S. Cox, McArthur	H. D. Chamberlain, McArthur	3d Wednesday, monthly.
Tenth District			
Crawford	M. L. Helfrich, Galion	C. J. Griebling, Galion	1st Monday, monthly.
Delaware	J. K. James, Delaware	W. E. Borden, Delaware	1st Tuesday, montbly.
Franklin	E. G. Horton, Columbus	Drew Davies, Columbus	1st four Mondays, montbly.
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Madison	R. W. E. Irwin, Mt. Sterling	F. A. Lutz, Mt. Sterling	4th Wednesday, monthly.
Morrow	C. E. Sherman, Cardington	T. Caris, Mt. Gilead	Last Thursday, monthly.
Pickaway	R. S. Hosler, Ashville	E. R. Austin, Circleville	1st Friday, monthly.
Ross	O. P. Tatman, Chillicothe	W. C. Breth, Chillicothe	1st Thursday, monthly.
Union	P. D. Longbrake, Marysville	H. E. Stricker, Marysville	2d Tuesday, monthly.

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MANAGEMENT OF COMMON DUCT STONE AND OBSTRUCTION

By FRED M. DOUGLASS, M.D.,

TOLEDO, OHIO

DURING the past five years many articles have been written concerning obstruction of the biliary tract due to stones in the duct system. The author wishes to consider 116 cases of obstruction in either the hepatic or common ducts which occurred in a series of 1635 operations performed upon the gall bladder and its ductal system. A review of the literature has been purposely omitted and the remarks will be confined to the author's personal experience in the management of obstruction of the ducts.

In reviewing the end results in this series of cases, two problems have made themselves manifest. The first has to do with the lateness with which these cases come to the surgeon. If we are to believe that infection occurs first, and stone formation later, and that infection in the gall bladder begins long before the disease spreads to the ductal system itself, the problem can be solved by the recognition of these cases at an earlier date. The author has been impressed with the number of attacks which the patient has suffered before surgery intervenes. If these cases could have been operated upon earlier (in many instances ten or more years have elapsed since the first attack began), there is no doubt in our mind that the condition would never have progressed beyond the gall bladder itself, and in turn, we would not see the number of cases in which permanent damage has been done to the liver and its drainage systems. If we but stop to consider the mortality for operation upon the ducts as compared with cholecystectomy, we are forced to the conclusion that it not only is not fair, but decidedly wrong, to permit patients to withstand repeated attacks of gall stone colic.

The second problem has to do with the choice of operation necessary to correct the pathology present. It goes without saying that a careful history and examination with complete laboratory findings, are most necessary in the establishing of the diagnosis and the patient's operability. Every effort is made to place the patient in the best possible shape to withstand the operation. The giving of fluids in large quantities by mouth and subcutaneously, is most necessary. Glucose is given in large qnantities intravenously as well as by mouth and subcutaneously. Blood transfusion is a very valuable adjunct both preoperatively as well as after operation. In this series, 25 patients received 39 blood transfusions. The operation is greatly facilitated by making an incision of sufficient size to permit a very good exposure of the gall bladder, ducts, and duodenum. The viscera are packed off, using Keefe's rubber pack, care being taken to free the duct along its entire course.

A good visualization is most important because

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of the anomalous variation of the ducts. The gall bladder is first emptied of its bile and stones; the aperture made to effect this is then clamped to prevent future soiling of this portion of the abdomen, and the so-called goose-neck of the gall bladder is grasped with a clamp and retracted upwards, thus putting tension on the common duct. The peritoneum over the duct is then incised, bringing the duct directly into view. An opening is then made as near the duodenum as is possible, as this makes removal of the stones from the ampulla of Vater much easier, for it is in this spot that stones are most frequently overlooked.

The patency of the passage into the duodenum is established by the introduction of a curved hemostat; the upper portion of the biliary tract is then explored by means of flexible probes and scoops. Very rarely is it necessary to irrigate the duct with saline solution, but occasionally this is done when small gravel are encountered. After it has been proved that there are no more stones in any of the ducts, a Deaver T-tube is prepared for introduction into the common duct. The lateral arms are usually shortened and an eyelet is placed at the base of the T. This last procedure makes for ease in introduction of the tube into the duct, as well as minimizing the trauma on removal. A cigarette drain is usually placed to Morrison's pouch, and recently we have been using a rubber catheter for the introduction of cololysate into the abdomen.

When the obstruction at the ampulla of Vater is such that a resection of the duct itself is necessary, there are but two procedures of choice: either a cholecystoduodenostomy if the gall bladder has not already been removed, or an anastamosis of the resected duct over a tube into the duodenum. We wish to emphasize again the need of conserving the gall bladder until patency of the ampulla of Vater has been definitely established. After the ambulla has been sounded and proved free from stones, and patent, then the gall bladder is removed in the usual fashion. We are particularly anxious that even the small contracted gall bladders are not left in place, because this small focus of infection may defeat the drainage operation, tending towards further chronicity.

In the very bad risk patients where jaundice accompanies acute or subacute gall bladder disease, a two-stage procedure should be carried out. The common duct is opened, but the added risk of cholecystectomy is avoided. It is our feeling that the jaundice case of long standing with a large dilated duct, should be decompressed gradually; that is, a T-tube is introduced and clamped for varying intervals so as to slowly reduce the pressure in the common duct. We believe that two of the deaths in our series resulted from not adhering to this procedure.

Inflammatory obstructions result from a combination of trauma and infection, as perforation by stone either in the duct, or as result of a surgical accident usually at the time of previous cholecystectomy. When this presents itself, the operator must do something which will prevent the re-formation of the scar which is the cause of the obstruction, partial or complete as the case may be. After the stones and scar have been removed, a catheter is placed into the common duct, allowing three inches of it to protrude into the duodenum, the funnel end of the catheter being placed above the inflammatory obstructed area, and is anchored in place with linen sutures. We have modified this method of McArthur by making a small opening in the catheter at the site of the aperture in the common duct, and through this hole in the catheter, an especially prepared T-tube is inserted. This allows for external drainage, permits the giving of glucose solution enterically, and makes *X*-ray study of the biliary tree available. The T-tube can be removed easily without injury to the duct, and the peristaltic action of the duodenum produces a continual tugging of the catheter which causes it to pass per rectum after four to eight months. At the end of this time, the inflammatory obstruction has usually been done away with, and a normal common duct remains. Our results with this procedure have been most gratifying.

The determination of the proper time for removal of the T-tube is one of the most important steps in the after-care of the case with obstruction of the common duct. The old method of clamping the tube, having the patient symptom free, with evidence of bile in the stool, is not considered enough positive evidence that the inflammatory process in the ducts has subsided. During the past four years, we have injected a solution of brominol into the duct by way of the T-tube, and have watched it pass by means of the fluoroscope. A plate is taken usually 15 minutes after introduction of the dye into the duct, and again after one hour has elapsed. In all cases where the dye passed readily into the bowel, the common duct may be considered as normal, and according to our follow-up, the results are not only good, but permanent. On four occasions tubes were removed either accidentally or otherwise, when the dye did not pass readily into the bowel, and in every case there has been a return of symptoms which necessitated the replacement of the T-tube into the common duct.

It is interesting to note that 86 per cent of these operations were done in females as compared with 14 per cent in males; the youngest was 20 and the oldest 81 years of age; the onset of symptoms varied from three months to 27 years, with one-fifth of the patients having had symptoms under one year and one-third over five years; the majority, however, having had symp-

toms well beyond the ten-year mark. In the common duct stone cases, history of jaundice could be obtained in only 60 per cent. The fact that 40 per cent of cases with common duct stones did not have jaundice, is of interest because of the teaching of some years ago that stones in the common duct were always attended with jaundice at some time or another.

The vast majority of patients complained of nausea and vomiting; 97 per cent of the cases studied suffered pain. Chills accompanied with fever occurred in 33 per cent of these cases; 66 per cent of this group had elevation of temperature upon admission to the hospital, varying from one-half to four degrees. The WBC parallels the activity of the infection present, varying from a low of 4,300 to 17,000. Nineteen of the 116 cases had had previous operations on the gall bladder, eleven cholecystostomies and eight cholecystectomies. One hundred and nine cases had stones either in the common or hepatic ducts, in many cases both. In five cases of stone in the common duct, malignancy of the common duct was found. On eleven occasions the common duct was opened and explored when no stones could be palpated and in seven of these cases, stones were removed. In four cases where the duct was opened and no stones encountered, the procedure was done because of a pancreatitis, marked hepatitis, or a very firmly infilitrated duct which prevented satisfactory palpation.

In the series of 116 cases, there were 17 deaths. Six died of myocardial disease and five of postoperative pneumonia, the remaining as follows: pulmonary embolism one, hemorrhage one, peritonitis two, and liver insufficiency two. Of the 99 patients surviving the operation, only four have any of their original symptoms and these four are greatly improved. The deaths occurred in cases with long standing symptoms and we do not feel that a mortality rate of 14 per cent plus is too high when one considers the type of patient which usually presents herself with common duct obstruction.

In conclusion, may I stress again the need for the earlier operation of diseases of the biliary tract, that is, before the infection has extended to the duct system with resulting stone formation and obstruction; the careful selection of the operative procedure necessary to deal with the pathology found; and the use of the *X*-ray in deciding when the T-tube should be removed from the common duct. We are making a study of the biliary tree and hope to be able at some time in the near future, to say with some degree of certainty how much damage has been done to the liver itself.

421 MICHIGAN STREET.

THE TREATMENT OF AMBULATORY RHEUMATIC HEART DISEASE

By ALBERT F. KUHL, M.D.,

DAYTON, OHIO

MUCH has been written about rheumatic fever and the rheumatic type of heart disease, but little thought has been given to the care and treatment of the ambulatory case. It is understood that an ambulatory case in adults or children is one in which the convalescence has been well enough established to allow the patient to be on his feet from brief intervals to the entire day. Before this time, the clinical signs of an active disease will have disappeared. The temperature will have remained under 99.5° for several weeks, without salicylates or other antipyretics. The maximum basal pulse rate will not exceed 100 per minute, and should return to its previous resting basal rate three minutes after a moderate exercise test, such as walking across the floor one or more times. The rate should not exceed 100 to 110 and the color should remain good under these conditions. The leucocyte count and erythrocyte sedimentation rate should be within normal limits. It is also important to note an increase in weight in children at this time.

It is this type of case which the doctor in general practice commonly sees in his office and which is often treated with indifference or misapplication of the accepted methods of treatment. Too frequently digitalis is given with a reassuring pat on the back and a request to return later. The early weeks or months of such a case not only require a thorough understanding of it, but boundless patience, tact and control. Details of the daily progress of the patient are indispensable to the doctor in directing the convalescence. Teaching the patient many of the practical facts about his disease will not only help to eliminate fear, but will result in gaining intelligent cooperation. There is no disease in which the patient's understanding of his case is of more importance. Still it is frequently neglected or

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From the Cardiac Clinic of the Miami Valley Hospital, Dayton, Ohio.

overlooked. No one will question the importance of this method in the successful management of tuberculosis or diabetes mellitus.

Most of the cases observed at the Cardiac Clinic of the Miami Valley Hospital have been well managed cases which came to the clinic because they could not afford a private physician. It was noted however, that frequently cases were at a disadvantage for want of more favorable management. These cases may be classified under three groups. 1. Undiagnosed cases with a rheumatic history. 2. Properly diagnosed cases. 3. Cardiac murmurs misinterpreted.

Many ambulatory cases of the rheumatic type of heart disease fail to give a clear-cut history of rheumatic fever. The attack may have been mild and made no lasting impression, or may have occurred in early childhood, in which instance the patient may not have learned of his condition. However, in most cases, a careful history will elicit the evidence of rheumatic fever, providing its manifestations are kept in mind. The evaluation of such a history with the clinical picture will facilitate an accurate diagnosis and bring patients in this group under proper treatment.

In the second group, i.e., the known cases of rheumatic heart disease, it was noted that some patients being treated as ambulatory cases were in need of bed rest. It is evident that this type of case is found most frequently in the free clinic or poverty stricken class of patients, since they avoid the expense of medical care. They must again be restricted and cared for as patients in the initial attack. It is also in this group that we note the results of faulty estimation of functional capacity. As for drugs, there will always be a variance in their selection and administration.

The group of cases with cardiac murmurs and no manifestations of active pathology must be considered. Many cases in this group have been needlessly impressed with the fear of heart disease by the mere presence of a murmur. We have long been taught the folly of such methods. It is common to find a mitral or aortic murmur with a definite history of rheumatic heart disease which, following recovery, has given no evidence of impaired cardiac function. Unnecessary caution and limitation in such a case can only result from misunderstanding. In mitral stenosis, respiratory distress is a fairly reliable guide. It causes the exercise to cease before the heart has been subjected to prolonged strain. Aortic insufficiency presents other mechanical factors. For a long period, there is no disproportion between the blood volume entering the heart and that which it is delivering. Therefore respiratory distress does not occur until late and when it does, the cardiac reserve has been exceeded and heart failure occurs. More rational advice in exercise allowance may be given by keeping these important points in mind. This has been elucidated by Barr in "Exercise in Cardiac Disease", Journal, A. M. A., 1928.

Treatment of the ambulatory case must include factors equally as important as drugs. With proper care, the outlook for many of these patients is very good. Those with enormous hearts, which have suffered four or five relapses are quite sure to have more attacks. Less seriously effected cases may recover to a greater extent than would seem possible. Our immediate concern in treatment is the degree of muscular weakness rather than the quality and number of murmurs. The estimate of functional capacity is positively necessary before intelligent direction in exercise can be given. Cases convalescing from an acute attack or exacerbation of rheumatic heart disease should not be subjected to severe exercise tests but should be allowed to walk or exert in a moderate way, compatible with the given case. Cases with slight impairment and those with definitely healed lesions may be given the usual exercise tests. It is important to note the pulse and respiration before and immediately after the tests, also three minutes later.

The doctor should also have detailed knowledge of the patient's tolerance of the various forms of exercise during the routine of a day. With such a rounded picture he will be qualified to direct the gradual increases in exercise. Patients often receive general directions from their doctors such as, "take it easy," or "don't do any heavy work," which means little or nothing to them. These directions should be specific and preferably written. Finally he is ready to direct his patient in occupational therapy. The successful management of an adult in the ambulatory stage depends on the kind of employment from which he must gain a livelihood. The physician should be responsible in suggesting the type of employment which in his opinion will be compatible with the patient's functional capacity. Such a selection may be made from skilled or unskilled occupations for men and women and may be graded from ordinary occupations where little caution is necessary, to lighter work as clerking or sitting work, as watch making, bookkeeping, dressmaking, etc.

Diet is usually very confusing to the patient and considered relatively unimportant by him. It is another item in the care of these cases which requires specific and written instructions. Some of them have digestive difficulties, due to chronic passive congestion, limiting them to smaller quantities of food at a given time. They frequently do better on four or five nourishments a day. The most common mistake is over-eating with either immediate dyspeptic effects or a resulting obesity which is a disadvantage to an impaired myocardium. It is invariably helpful to reduce obese patients. It should be done slowly, i.e., in an adult, not to exceed two to three pounds per

week and it should be discontinued when the patient no longer responds favorably to it. No other treatment will be of greater importance or initiated with more rational indications.

If the patient has a tendency to oedema, salt elimination should not be overlooked for it is often an important factor. Fluids should be restricted to 1000 cc. daily, until the oedema has been overcome and not allowed in excessive amounts thereafter. In cases where the cardiac reserve is limited it is a favorable practice to use the Karrel diet one day of every week, i.e., a glass of milk four times during the day. The regulation of protein intake should depend on the degree of renal impairment of the patient. If he is losing large amounts of protein in the urine, increased protein intake is demanded by the tissues. Children should be expected to show a favorable weight increase. It should be remembered that weight loss is likely to precede a relapse. It should always serve to put the doctor on his guard for other symptoms of active disease.

Hygienic measures are of utmost importance in the care of ambulatory cases. Periodic examinations should be made. The upper respiratory tract should be carefully observed for the presence of infection. Sinusitis should be eliminated if possible. The tonsils will have been removed before this time. However, any evidence of lymphoid tissue in the throat should lead to its removal at the earliest possible time. This may have to be done more than once. The avoidance of contacts with respiratory infections cannot be over-emphasized. These patients are susceptible and should not have to face the danger of an exacerbation from an avoidable source. They should not be allowed to attend public school or any groups, until their resistance and general health justifies it. A tropical climate would appear to be advantageous to the ambulatory case as the possibility of recurrence is lessened. Sunlight in the temperate climates is of value and should not be neglected. These patients should be encouraged to take sunbaths from early spring until late fall. A four-sided canvas inclosure with a cot suffices for this purpose. General tonic exposures of ultraviolet light should be used throughout the winter months.

Of the drugs that are used in the ambulatory case, digitalis no doubt holds its time honored place. While it is indicated in the congestive type of heart failure it cannot be made to take the place of restriction and rest. Patients who have a tendency to exceed their functional capacity, who have little cardiac reserve, are facing disaster when they depend on digitalis and forget rest. With adequate restrictions, it may be wisely used in cases with impending failure. It is frequently used in the ambulatory case with auricular fibrillation or flutter. It is given until the heart rate is slowed or until normal rhythm has been established.

Those cases in which fibrillation persists under adequate digitalis therapy are probably fixed fibrillators and should be given digitalis according to the effect in the given case. While some of them do satisfactorily without the drug, most of them benefit from some cardiac slowing. There are some cases with a poor cardiac reserve in which a daily tonic dose of digitalis adds greatly to the comfort of the patient. There is no more reason for giving digitalis to a case with an exacerbation of rheumatic heart disease because of a rapid pulse, than there is for giving it to a case of pneumonia or other febrile illness, unless one of the above indications accompany the acute illness. Our dosage has not differed from the accepted methods, and we also expect individual variations not dependent on the weight. Therefore we give 1½ grains to the average adult, three or four times daily until we observe evidence of digitalis effect. The dose is then reduced to a maintenance dose of about 1½ grains daily.

Salicylates are evidently the most efficient antipyretics and analgesics for the treatment of acute rheumatic fever. But they will not take the place of bed rest in an impending exacebration. They are commonly administered to ambulatory cases over prolonged periods with an idea of preventing an exacerbation. According to Paul White, prolonged salicylate therapy may depress the production rate of immune bodies and abolish temporarily symptoms and signs, including fever and leucocytosis. There is no good reason for administering salicylates in the ambulatory case.

Oedema due to congestive heart failure often occurs when the treatment is designed to avoid it, i.e., while the patient is receiving an adequate dose of digitalis and is being restricted in diet, liquid intake and physical activity. Complete rest should be instituted until the oedema has disappeared. Theobromine should first be tried, giving 5 to 10 grains of the alkaloid three times a day. The effectiveness of the drug will be prolonged if intervals of two or three days are allowed between courses of five to six days.

If there is no response to this drug other xanthine derivatives may be tried. We have used theophylline and aminophylline in doses of 1½ to 3 grains orally with satisfactory results. The same interval method mentioned above should be used. One should always be on his guard for the toxic symptoms of these drugs, nausea and vomiting. A rest interval at this time usually overcomes the difficulty. A refactory case may require a more powerful diuretic. We first resort to salyrgan, 1 to 2 cc. intravenously which if effective may be repeated every four days if necessary. In obstinate cases, ammonium chloride,

gr. xx, four times a day was used as an adjuvant.

After relieving the oedema of the tissues which may have been the greatest factor in embarrassing cardiac function, these patients maintain compensation over surprisingly long periods of time. Let me recall then, that congestive failure with normal rhythm may be due to a weak myocardium which is not subject to improvement of tone by digitalis therapy. Therefore the importance of removing oedema becomes more apparent.

The ambulatory case may go along for months or years without the aid of drug therapy, but the judicious and timely administration of drugs may play an important role. Sedatives and hypnotics are usually the first drugs to be used in the mild disorders of an ambulatory case and in our clinic have held a popular place. Many of these patients are victims of cardiac neurosis or neuro-circulatory asthenia and may be given bromides for this reason, but they should not be restricted to this group alone. The results of their administration in moderate degrees of congestive heart failure are frequently gratifying and equally as dramatic as a good digitalis response.

It is important at this point, to prevent the patient from dissipating the immediate benefits of the drug by correcting the factors which gave rise to the break. Our average adult dose is 15 grains three times daily and for children, approximately half the dose was given. Our prescription has consisted of the elixir of five bromides. For hypnosis we used phenobarbital, in doses of 1 to 3 grains, one or two hours before bedtime. Often it is necessary to alternate with amytal, ortal sodium and others to obtain continued results. A dose of morphine should be given when the distress and restlessness cannot be relieved by these more simple measures. If it has not been used too often it usually produces the desired results in rest and comfort to an over-tired and anxious patient. Frequent use of the drug should be avoided if possible.

Ambulatory cases commonly present varying degrees of secondary anaemia and should be treated when they are observed. Liberal doses of iron, that is, reduced iron, grams 1½ daily, or ferric ammonium citrate, grams 4 daily, will often restore a normal red cell count. Cases, slow to respond were managed not unlike any case of secondary anaemia.

SUMMARY

Ambulatory rheumatic heart disease is often treated with indifference. Patients should be taught the practical facts about their disease and should be kept under the direction and control of the physician.

Greater care in diagnosis will improve the treatment and management of these patients.

Estimating functional capacity of the myocardium rather than undue emphasis on cardiac murmurs is necessary before intelligent direction of exercise and occupation can be given.

The judicious use of drugs is indispensable in selected cases. The indiscriminate use of digitalis and salicylates is often productive of more harm than good.

The main item in the therapy of ambulatory rheumatic heart disease is the preservation of the myocardial reserve by adequate rest.

HARRIES BUILDING.

DISCUSSION

V. C. ROWLAND, M.D., Cleveland: Doctor Kuhl's paper is really a very excellent presentation of an important subject in a practical and well-balanced way. The subject is important because of the great opportunity for personal preventive medicine in connection with the ambulatory cardiac patient. Heart mortality is steadily increasing yet there is great neglect of the chronic cardiac case without definite symptoms. Personal interest and intelligent supervision may lead to a great variety of measures to prevent premature breakdown.

In the first place, as Doctor Kuhl has indicated, rheumatism should be treated as a chronic infection and the nearer the regimen is brought to that long accepted for tuberculosis by prolonged rest, the better the end result will be. The criteria for a controlled infection set down by Doctor Kuhl are definite and helpful and certainly are not too exacting in connection with recent rheumatic infections.

Anemia requires vigorous treatment in these cases. Osler long ago called attention to the fact that rheumatism causes a very rapid and sometimes severe anemia. Minot has called attention to the necessity of massive doses of iron in the full control of some secondary anemias such as 100 grains daily of iron ammonium citrate in the adult. It may also be supported by liver extract to advantage in these rheumatic cases. As long as the chronic rheumatic heart case has a definite anemia he is not being given the best protection against relapse. The removal of foci of infection, of course, nowadays is sufficiently emphasized.

The older rheumatic case with a tendency to excess weight and hypertension presents a very definite preventive opportunity by dietetic control and weight reduction. It is well established that obesity means extra cardiac load and often increased metabolism and hypertension and an increased susceptibility to infection. Not enough attention is paid to the statistical facts in regard to increased mortality rates observed by the insurance companies in connection with various degrees of excess weight. This increased mortality is largely due to cardiac disease. A balanced diet of milk, eggs, meats, vegetables, and fruits simply low in total calories is all that is necessary to control excess weight in the great majority of individuals.

Medicinal treatment I think, Doctor Kuhl has discussed and appraised very accurately.

Vocational training comes up in the well controlled case with normal blood and normal weight, cleared of infectious foci, etc. The handicapped patient needs vocational training more than the normal individual and the experience of specialists in this field is that in normal times there is no placement problem with the trained individual.

The great difficulty is with the untrained cripple, cardiac or otherwise. The Bureau of Vocational Rehabilitation under the State Department of Education of Ohio has a number of trained people in this field who are competent to advise in connection with specialized training and the opportunities for placement. When such an individual is trained for special work it should be remembered that control of the number of hours of work is more effective and practical in connection with heart symptoms than a change of work or entire stopping of work.

Birth control nowadays is of particular importance to the young married woman especially with mitral stenosis and as Lewis points out particularly with fibrillation, poor exercise tolerance or a recent rheumatic infection.

Finally when nothing else avails one should keep in mind the remote chance of surgical relief as by cardiolysis or pericardiectomy in adhesive mediastino-pericarditis with recurrent ascites and possibly also total thyroidectomy to lower metabolism in a heart which promises to be unable to carry on. This work is still definitely in the experimental stage but one point I believe is definite, namely, that if these cases are allowed to go on too long in chronic decompensation the vast majority will die of bronchial pneumonia after total ablation of the thyroid gland. If this is to be undertaken it must be considered at an earlier stage.

Doctor Kuhl is to be congratulated upon this important work and I am very sure he is able, by the methods he indicates, to prolong the lives and to increase the happiness and usefulness of his cardiac patients.

EPIDEMIC ENCEPHALITIS

By P. GEORGE TAIT, M.D.,

TOLEDO, OHIO

THE symptoms of encephalitis occurring in different epidemics were similar in some respects but varied in kind and degree in different epidemics and also in the same epidemic. Encephalitis lethargica first observed by Von Economa of Vienna in 1917, and occurring in epidemic form in 1918 and sporadically since, is different from the epidemic occurring in St. Louis and other places in United States in 1933, which appears to be similar to the epidemic occurring in Japan in 1924 and 1929 and to that occuring in Paris, Illinois, in 1932.

While only two cases were observed in the acute stage in the recent epidemic, a large number were seen in different stages following the epidemic of 1918 and in these cases the symptoms varied in kind and degree, many being so mild at time of acute attack that they were overlooked and the patient did not know he had the disease until months or years later, when he developed Parksonian symptoms; while in other cases the symptoms were typical, easily recognized, and the patient either died, completely recovered, or apparently recovered, and later showed evidence by certain symptoms of having had the disease at some time.

Although the symptoms and course of encephalitis lethargica vary, there are certain symptoms at certain times. According to these symptoms the disease is divided into different stages, the acute, the sub-acute or psycho-neurotic and the chronic stage in which Parkinsonian symptoms are common.

Read before the Section on Nervous and Mental Diseases, Ohio State Medical Association, at the 88th Annual Meeting, Columbus, October 4-6, 1934.

In the acute stage the symptoms vary. There may be a grippe-like infection with little or no evidence of nervous system involvement, but usually the onset is rather sudden with headache, some drowsiness, nausea, vomiting, dizziness, often with muscular twitchings and transient diplopia, when a fever develops of varying degree and with it certain symptoms which classify it into several different types, the two main types of which are:

1. The somnolent opthalmoplegic type
2. The irritable hyperkenetic type.

In the somnolent opthalmoplegic type there is pathological drowsiness of varying degrees accompanied by eye muscle disturbances, one of the most frequent of which is diplopia. In this stage we may have paralysis of any eye muscle of varying degree, other forms of paralysis, vertigo, nystagmus, neuralgic pains, or other symptoms, dependent upon which part of the cerebro-spinal system is involved.

In the irritative hyperkenetic type of the acute stage we see purposeless muscular movements of two types:

(a) The choreic, in which the movements are similar to Sydeham's chorea, and

(b) The monoclonic type in which there are involuntary contractures of single muscles, which are simpler and more monotonous than the choreic type.

The acute attack may last from a few days to several months. After the acute stage has passed, we often see a second stage called the psychoneurotic stage, which is characterized by exhaustibility, lack of initiative, in which the patient is restless, irritable, emotional, introspective, and complains of many vague symptoms. Often in this stage the neurological and serological findings are negative and when seen for the first time with no history of an acute attack, the diagnosis

of psychoneurosis is often made. This second stage may continue from a few weeks to many months. These psychoneurotic symptoms have been attributed to lesions of the hypothalmic controlling centers of the parasympathetic, but in a disease like this with the large involvement of part of brain, it is a question whether these symptoms are due to organic changes or are secondary functional symptoms.

The third or chronic stage may accompany or shortly follow the first or second stage, or may not appear until years later. In this stage, spoken of as Parkinson syndrome, the symptoms are similar to paralysis agitans. Here we have stiffness, followed by rigidity of muscles of neck, back and extremities, on account of which there is difficulty in performing movements, and all movements are slow and deliberate. The rigidity produces a tonic preservation of reflexes, so that the reflexes are usually exaggerated. Tone is much greater in flexion, so that the body is bent forward and the forearms and hands are semiflexed. The speech often becomes affected and is slow and monotonous, deglutition is sometimes affected and there may be coarse tremors of hands, legs and head.

In this stage we often have partial paralysis; eye symptoms may first make their appearance, and here we at times see the oculo-gyric crisis in which the eyes turn upward and backward, and various respiratory symptoms, which can not always be accounted for on an organic basis, and which are regarded by some as behavior conditions. In this stage choreiform movements may persist in a milder form than in the acute stage and various vegetative symptoms are common, the most constant of which is sialorrhea in which saliva drips from the mouth; marked increase in weight and symptoms of diabetes inspidus are often observed. Some of these cases become progressively worse and live only a few years, while many live a great number of years with no very great change in general health and neurological symptoms, especially if taking treatment, while others gradually become worse, become bedridden and often have endocrine or metabolic complications.

A number of cases that do not develop Parksonian symptoms show psychic disorders, as delusions of persecution, dementias, phobias and anxiety states. The symptoms described in which we have pathological drowsiness with eye symptoms, mainly diplopia or choreic disturbance, often followed by psychoneurotic symptoms and finally developing Parkinsonian disease, were observed in cases following the epidemic of 1918 and occurring sporadically since.

These symptoms were observed mainly in young people under thirty years of age. In the acute stage most of these cases showed a slight leucocytosis in blood, averaging about 10,000 leucocytes, while a number showed a normal leucocyte count. However, in a few cases the leucocyte count was below normal; the spinal fluid showed a slight increase in pressure and showed a slight leucocytosis from 15 to 50 cells, although a few showed a larger number of cells. In the sub-acute and chronic stages the blood and spinal fluid findings did not show much change.

In many of these cases the deep reflexes were hyperactive and often unequal, while a small number showed absent abdominal reflexes, and to this group of cases, which appeared to be only mildly contagious in the acute stage only, the term encephalitis lethargica is applied.

The recent epidemic of encephalitis occurring in St. Louis and other places in 1933 appears to be somewhat different from the cases described, occurring at the time of the war and sporadically since. In these cases the age was greater, the large number occurring in people over thirty years of age, and here cranial nerve involvement and eye symptoms, except for contracted pupils which were common, were not often observed, or when observed were of a transitory nature. There was a leucocytosis in the blood, showing from 10,000 to 30,000 white cells and there were marked changes in the spinal fluid, most cases showing a high white count from 200 to 500 cells, which was not marked in the cases of encephalitis lethargica. There appeared to be more meningial involvement and stiffness of neck muscles and Kernig's sign were common. The deep reflexes, although varied, were often diminished and the abdominal reflexes were absent, which was not often observed in other cases. The acute stage was of shorter duration and those that were not fatal appeared to make a good recovery. As in the cases so far observed, although some show mild sequallae, they have not shown evidence of a chronic stage or Parkinsonian symptoms. In the post mortem findings there appeared to be more involvement in the cortex than in the basal ganglions and to this group the term encephalitis "B" is applied.

ETIOLOGY

Epidemics of encephalitis lethargica have been associated with influenza, which has caused many to believe that both are caused by the same virus, but the etiology and pathology appear to be different. From cultures made from brain filtrate, spinal fluid and nasal pharangeal washings, a minute filtrable organism called globoid bodies of Loewe and Strauss were obtained. Rosenow from similar cultures has isolated a green producing streptococcus and believes the so-called globoid bodies of Loewe and Strauss to be smaller forms to this organism, but neither of these has been proven to be the cause of encephalitis lethargica.

The virus of febrile herpes has been considered the etiological agent, but this also has not been proved, so that thus far the cause of encephalitis

lethargica points to an unidentified virus capable of passing through filter.

A number of chains of virus causing encephalitis in mice were isolated from cases of encephalitis occurring in St. Louis during the summer of 1933. This virus is neutralized by the serum of individuals convalescent from the disease and is not neutralized by serum of individuals recovered from encephalitis lethargica. The etiology of encephalitis lethargica and that of the epidemic occurring in St. Louis appears to be different, due to different virus or to a different strain of the same virus.

RECENT ACUTE CASES SEEN IN SEPTEMBER 1933

Case I. Female, married, 64 years old. On September 20th, complained of severe headache and nausea and on the following morning vomited, complained of sore throat; developed a temperature of 104 degrees F. and became drowsy. Her temperature varied from 102 degrees to 104 degrees for five days, during which time she was drowsy, confused and apathetic; after which temperature gradually returned to normal within nine days with improvement in her mental condition.

Physical examination was negative except for inflamed throat.

Neurological examination. Sensation normal. All movements normal, no stiffness or rigidity of muscles. Superficial reflexes diminished except abdominals, which were absent. Deep reflexes of arms and forearms equal and normal. Patellar and achilles not elicited. No cranial nerve involvement, except that pupils were contracted, but equal and reacted slowly to light and accommodation. No nystagmus, no diplopia.

Special senses normal. Laboratory reports—Urinalysis negative, except for trace of albumen. Blood Wassermann negative. Blood examination —4,000,000 red cells, 18,000 leucocytes. Spinal fluid examination—Wassermann negative, 280 leucocytes. Trace of albumin. Trace of sugar.

As reports from St. Louis at that time did not favor the use of serum over other forms of treatment, she was treated with 25 per cent dextrose solution intravenously, spinal taps when headaches were severe, and symptomatically. She made a good recovery within two weeks except that several months later she lost her hair.

Case II. Male, 35 years old, seen about same time as Case I. Onset was sudden with severe frontal headaches and nausea for a day, when he developed a temperature of 104.4 degrees. The temperature ranged from 103 degrees to 104.4 degrees for five days during which time the patient was drowsy, confused and apathetic; after which temperature gradually returned to normal within ten days with improvement in mental condition and made a good recovery in two weeks.

Physical examination was negative except for inflamed throat.

Neurological examination. Sensation normal. Movements normal except for slight rigidity of neck muscles. No Kernig's sign. Superficial reflexes diminished except abdominals which were absent. Deep reflexes equal and normal. Patellars equal and normal. No Babinski, no cranial nerve involvement except that pupils were contracted, but equal and reacted slowly to light and accommodation. No diplopia, no nystagmus.

Laboratory reports: Urinalysis negative. Blood Wassermann negative. Blood count 5,000,000 red cells, 13,000 leucocytes. Spinal fluid examination: Wassermann negative. 500 leucocytes.

In both these cases the symptoms and findings were similar except that in one there were absent patellar reflexes and in the other rigidity of neck muscles. Both had infected throats, absent abdominal reflexes, contracted pupils and a leucocytosis in blood and spinal fluids.

Case III. Encephalitis lethargica with oculogyric crises. Female, married, 27 years old. First examined in June, 1932, at which time she complained of spells in which eyes would turn upwards and backwards occurring several times a day and lasting from a few seconds to several minutes; slight dizziness at times, of seeing double at times and of increased salivation. At that time patient said that about four years before she began to have attacks in which eyes would turn upwards and backwards occurring about once a week and lasting a few seconds to several minutes and after a few months these attacks became more frequent, occurring every day and sometimes several times a day. There was no history of any infection or condition similar to encephalitis, but shortly before these attacks came on she was in an automobile accident at which time she was dazed, slightly bruised and frightened, but suffered no other serious injury.

The family history shows father has a mental condition, a maternal uncle is an eptileptic, and a sister has hysteria. Physical examination was negative. Neurological examination. Sensation normal. Movements—No atrophy, no paralysis, slight rigidity of neck and back muscles and all movements were slow and deliberate. She was observed in spells in which the eyes would turn upward and backward and at times she would have a staring expression. At times during these observed attacks, she was able to focus her eyes on some object.

Examination between these attacks showed no evidence of any paralysis. Station normal. Walks with body erect, back rigid with slow measured steps. There were slight coarse tremors of extended fingers. All reflexes equal and normal. No cranial nerve involvement except at times she complained of diplopia. Pupils equal and reacted normally. No nystagmus, no strabismus. Eye grounds normal. Fields of vision normal. Special senses normal except for slow monotonous speech. Mentally she appeared slightly worried, had an anxious expression, was introspective, her stream of thought was slow and at times she appeared to be in a dazed or trance-like condition.

Jeleffe has collected a number of cases showing these eye symptoms and most of them gave a history of an attack of encephalitis and showed evidence of Parkinsonian disease. In this case there is no history of encephalitis or any infection and although she does not show the typical Parkinsonian syndrome, she shows evidence of it in her speech, stiffness of back muscles, slight tremors and drooling, and it would appear that she had an acute attack of encephalitis at some time, which was not recognized.

There have been various theories to account for these eye movements. In some cases nystagmus has been present and on account of some modifications in labyrinthine responses, met in cases in which vestibular tests were made, it is believed by

some that these movements are due to lesions of the vestibular nucli, or globus pallidus, while others believe there is a center for eye movements at or near the copora quadrigemia.

Jeleffe does not think that there is any organic lesion alone that can account for these movements and regards them as behavior reactions. In this case there is a neurotic family history and she gave a history of being frightened before onset of symptoms, her thought movement was slow, she appeared to be in a dazed or trance-like condition at times and in the period between attacks no evidence of paralysis was found. As there is no definite pathology to account for these symptoms, they were regarded as behavior reactions, as defense reactions, as in the compulsive neuroses and in this case it would appear that there has been a trauma in the brain of a person whose mentality was below par, on account of which a neurosis was imposed on an organic condition. She has shown considerable improvement with psychotherapy, stramonium and hyocine and at this time these spells occur only a few times a month and drooling is not noticeable.

Case IV. Encephalitis lethargica with respiratory symptoms. Male, 28 years old. Examined October, 1924, at which time patient complained of general weakness, tiring easily, deep and increased breathing when lying on back and spells in which breathing was fast and irregular. He gave a history of dull gnawing pains right side of abdomen in 1919 which gradually became worse and about 1922 of a spell in which he became drowsy and sleepy and would sleep twenty out of twenty-four hours, during which time he had a fever. Following this spell, which lasted several weeks, he noticed weakness in right arm and leg. He continued to have dull gnawing pains right side of abdomen, had difficulty in breathing at times and when lying on back, breathing was deep and more frequent. His physical examination was negative. Heart and lungs normal. When lying on back breathing was deep and increased, respirations being between 40 and 50 a minute.

Neurological examination:—Sensation normal. Movements—There was slight atrophy of right forearm but no paralysis. There was an increased tonus of muscles and all movements were slow and deliberate. Station normal. Walked with right forearm semiflexed against right thigh, with head slightly inclined forward, with upper part of body and neck slightly rigid, with an uncertain gait, slightly dragging right foot.

Superficial reflexes normal. Deep reflex of upper limbs equal and slightly exaggerated. Patellar unequal and exaggerated, the right more so than left. Right Babinski, right ankle clonus.

No involvement of cranial nerves, but when lying on back respirations were deep and increased. Pupils equal and reacted normally. No nystagmus, no diplopia. Special senses normal, except for slow monotonous speech. Laboratory reports at time of examination negative. Mentally appeared slightly depressed and worried.

As in the cases of oculogyric crises, there is a difference of opinion as to the cause of these respiratory disorders. B. Beilin believes that where there is disturbance of frequency and rhythm, they result from lesions of the subthalmic region; while where there is myoclonia, it results from striatal lesions. However, Jeleffe attributes them to be more of a symbolic than cerebral significance.

In this case, there is a history of dull gnawing pains right side of abdomen for several years before onset of symptoms of encephalitis, which appeared to be of a psychoneurotic nature, and the respiratory symptoms were regarded as behavior reactions, secondary to an organic condition, as in the case of oculo gyric crisis.

TREATMENT

In the acute stage of encephalitis the patient should rest in bed with quiet surroundings and receive symptomatic treatment indicated. In the acute stage of encephalitis lethargica good results have been reported following the injections of serum from patients convalescent from the disease, and also from intraspinal injections of patient's own serum.

In the recent acute cases of encephalitis "B", reports did not favor the use of serum over other forms of treatment. Good results were reported from frequent intravenous injections of glucose solutions and repeated spinal drainage. In collapsed and dehydrated individuals fluids were forced by mouth and subcutaneously. Good results were reported in some cases in which Rosenow's antistreptococcus serum was used.

In both epidemics various drugs were used and improvement noticed after their use. Among these were arsephenamine, sodium salicylate, iodine preparations and mercurochrome given intravenously.

In the treatment of the secondary or psychoneurotic stage of encephalitis lethargica, the patient should be given much rest and tonic treatment to prevent if possible the development of the chronic stage.

In the third or chronic stage of encephalitis lethargica, in which the main symptoms are rigidity, tremors and drooling, drugs to alleviate these conditions are given. For the increased, tonus, bellanoda and stramonium are given, and of these stramonium seems to act best. Tincture of stramonium is given in gradually increased doses, but little effect is reached until 30 to 90 drops three times a day are given.

For the tremors, hyocine gives best results. Both of these drugs have a good effect on drooling.

Not much effort has been made to treat the chronic stage, except symptomatically. But as the disease, like syphilis, appears to be a chronic progressive disease, it might be treated like syphilis by various drugs that kill the virus or absorb exudates, and treatment with arsenicals and iodides might be beneficial.

340 NICHOLAS BUILDING.

OBSERVATIONS ON THE GROWTH AND STATE OF NUTRITION OF PREMATURE INFANTS GIVEN AN ANTIRACHITIC AND ANTISCORBUTIC FOOD

By ARTHUR J. HORESH, M.D., and
G. RICHARD RUSSELL, M.D.,

CLEVELAND, OHIO

INTRODUCTION

THAT human milk is the ideal food for the premature infant appears to be the consensus of opinion of all investigators interested in this field. But it has also been claimed by many observers that modifications of human milk, especially relative to its protein content, often prove more satisfactory in producing optimum progress. It is believed that while the protein content of woman's milk is adequate for the full-term infant, it does not always fulfill the needs of the premature whose demands for protein are higher and whose ability to take the necessary quantities of food is less. These modifications of human milk have taken various forms. Poole and Cooley[1] have found that the addition of 2 per cent calcium caseinate to the milk makes a very satisfactory formula. Hill[2] used a mixture of three parts breast milk and one part evaporated milk. Zeltner[3] added proprietary protein compounds. Langer[4] reported good success with the use of a casein preparation. Thompson[5] concentrated the milk, by evaporation, and Emerson and Smith[6] used dried breast milk. Judging from the results of these methods, one must agree with these investigators that human milk reinforced with protein proves superior, in the majority of the cases, to human milk alone.

Unfortunately, all mothers cannot supply their infants with human milk and all clinics do not have it readily available. Consequently, it often becomes necessary to resort to artificial feeding. To provide a suitable milk substitute for infants unable to receive breast milk, Gerstenberger *et al.*[7, 8] recommended the use of a fat adapted milk which, when diluted according to directions, is essentially similar to human milk in percentage of protein, fat, carbohydrates and ash, in chemical constants of the fat and in physical properties. To suit certain deviations from normal, such as the premature infant, who, it appears, requires an intake higher in protein[5] and in minerals (Hamilton[9]) than does a full-term infant, and who is more susceptible to digestive disturbances, a modification of this milk seemed to be indicated and therefore was made. The resultant product* is a powdered acid protein milk similar to casein and lactic acid milks and has a pH of 4.6. The acidity is obtained by adding 20 cc. of lemon juice to a milk in which lactic acid has been produced by controlled bacterial fermentation. One-fifth of the acidity is due to the citric acid added in the form of the lemon juice and four-fifths to lactic acid. The lemon juice provides the antiscorbutic factor which has been found adequate for the cure of scurvy[10] in infants. The fat of the milk is a mixture of animal and vegetable fats, including biologically tested cod liver oil, and has character numbers that are practically identical with those of human milk. The cod liver oil content is 3.8 cc. per quart. The approximate analysis of this milk when diluted (30 grams of powder added to warm boiled water made up to 300 cc., or 9 oz. of warm boiled water for every ounce by weight of powder) is as follows:

Protein	3.5
Fat	2.2
Carbohydrate	2.8
Ash	0.6
pH	4.6
Calories per ounce	15
Calories per 100 cc	50

During the past eight years at the Babies and Childrens Hospital in Cleveland, Ohio, fifty-three premature infants have been fed this milk food for periods varying from one to eight months. Twenty-two of these infants received the milk exclusively from birth up to the time of discharge from the hospital, a period averaging about six months. It is the purpose of this report to present our experiences with the use of this preparation in premature infants together with an analysis and evaluation of our clinical results.

PLAN OF STUDY

Proper rearing of the premature infant requires, in addition to the selection of a suitable food, intelligent nursing and medical care, strict prophylaxis against infection and meticulous care in the stabilization of body temperature. Blackfan and Yaglou[11] clearly demonstrated the importance of environmental conditions, such as temperature, humidity and ventilation. Our study was carried out in an institution where all the above-mentioned conditions of care and surroundings were kept as uniform as possible. The majority of the prematures in our series were delivered at home. About 60 per cent of our cases reached the hospital within one to 24 hours after birth. The remaining cases were admitted from two days to five weeks after birth.

At the time of admission a bed heated to from

From the Babies and Childrens Hospital, Cleveland, and the Department of Pediatrics, School of Medicine, Western Reserve University.

*Protein S.M.A. (Acidulated).

36° to 38° C. was found ready for the infant. This bed is a regulation size bassinette and was heated with ordinary 25 watt electric light bulbs suspended from a cradle. The clothing consisted of a wool shirt, diaper, stockings and a premature jacket. Rarely were blankets required with this heating system. Rectal temperatures were taken every three hours routinely and more often if indicated. We tried to keep the infant's temperature at all times somewhere between 37° and 38°C. Unfortunately, our special premature room was not available and all of our infants had to be cared for on the infant wards. The temperature of the wards was maintained between 68° and 72° F. by thermostatic control. Sufficient moisture in the air was provided by two large humidifiers which during the winter months were kept in almost constant operation. The relative humidity varied between 40 and 60 per cent. Warm oil baths were given three times weekly. Water baths were withheld until the infants weighed at least 3000 grams. To enable us to maintain equable temperatures in our infants, we subjected them to the minimum amount of handling. They were removed from the beds only for weighing, special treatments and for special observations. The physicians made few examinations and were guided chiefly by a study of the charts and the character of the stools. Infection was guarded against by strict isolation of the individual cubicles, limitation of visitors, avoidance of handling and strict supervision of the attending personnel.

TABLE 1.

REPRESENTATIVE FEEDING SCHEDULE DURING FIRST THREE WEEKS OF LIFE FOR PREMATURES OF VARIOUS WEIGHT GROUPS GIVEN PROTEIN S.M.A. WITH 6 PER CENT ADDITIONAL CARBOHYDRATE

Day of Life	Birth Weight Approximating 1250 grams			Birth Weight Approximating 1750 grams			Birth Weight Approximating 2250 grams		
	Feedings*		Approximate No. Calories per Kilo per Day	Feedings*		Approximate No. Calories per Kilo per Day	Feedings*		Approximate No. Calories per Kilo per Day
	No.	Amount		No.	Amount		No.	Amount	
		cc.			cc.			cc.	
1	No food for 12 hrs. then 5	5		No food for 12 hrs. then 5	5		No food for 12 hrs. then 4	8	
2	10	5	30 - 35	10	5	20 - 25	8	8	20 - 25
3	10	6		10	7		8	10	
4	10	7		10	8		8	13	
5	10	8		10	10		8	15	
6	10	9		10	11		8	18	
7	10	10	55 - 60	10	13	55 - 60	8	20	55 - 60
8	10	11		10	14		8	23	
9	10	12		10	16		8	25	
10	10	13		10	17		8	28	
11	10	14		10	19		8	30	
12	10	15		10	20		8	33	
13	10	16		10	22		8	35	
14	10	17	95 - 100	10	23	95 - 100	8	38	95 - 100
15	10	18		10	25		8	40	
16	10	19		10	26		8	43	
17	10	20		10	28		8	45	
18	10	21		10	29		8	48	
19	10	22		10	31		8	50	
20	10	23		10	32		8	53	
21**	10	24	130 - 140	10	34	130 - 140	8	55	130 - 140

*Additionel water in form of 5 per cent Kero solution wae offered in amounte of 60 to 150 co. daily.
**By end of third week an amount of approximately 200 co. per kilo of hody weight was reeched end maintained thereefter.

METHOD OF FEEDING

A more or less standardized plan with respect to feeding was followed as often as possible. Premature infants, however, differ so much in their ability to ingest and tolerate food that no fixed feeding plan can apply to all of them. The milk food described, with 6 per cent additional carbohydrate in the form of corn syrup, was employed in the majority of cases. In the smaller premature infants 1¼ strength formula was used occasionally to insure an adequate intake of calories. If there was a tendency to develop loose stools, the carbohydrate concentration was temporarily diminished.

In general, during the first two weeks of life, a minimum amount of food was offered, as during this period the premature infant's tolerance for food is very low and to overstep that tolerance usually means failure. No food was offered during the first twelve hours. Thereafter small amounts of the milk were given at frequent intervals as shown in Table 1.

Infants weighing less than 2000 grams were fed ten times in 24 hours, at 2 to 2½ hour intervals. Infants over 2000 grams were given eight feedings in 24 hours, at 3 hour intervals. Whenever possible, a bottle with a small nipple was employed. The majority of infants, however, were fed by means of a medicine dropper fitted with a rubber tip. Rarely did we resort to the use of a Breck feeder or to gavage. The infants were fed in their beds with their heads slightly elevated on the nurse's hand to facilitate swallowing. We attempted to reach and we rarely overstepped, in the form of the milk food mixture, an energy quotient of 55 to 60 calories per kilogram per day by the end of the first week, and 95 to 100 calories per kilogram per day at the end of the second week. After the end of the third week most of our infants were receiving and tolerating an equivalent of approximately 150 calories per kilogram per day, which amounts, in terms of the food mixture described above, to an intake of 200 cc. per kilogram of body weight per day. This quantity was, in fact, found to be definitely sufficient to maintain satisfactory gains after the third week of life. After the second month, when tolerance to food was well established, we often

increased the carbohydrate concentration to 9 or even to 12 per cent. It should be emphasized at this point that the amounts just given and the amounts stated in Table 1 are maximum and must be reduced, should any tendency to diarrhea or vomiting be present. In our series none of the infants received solid food until just before discharge from the hospital.

Of great importance, especially during the first few weeks of life, is the water intake. We avoided, whenever possible, the administration of fluids by saline hypodermoclysis. In addition to the milk we have succeeded in most cases in administering a 5 per cent corn syrup solution orally in amounts varying from 60 to 150 cc. daily during the early weeks. When dehydration became severe or when infection supervened, it was often necessary to resort to daily infusion with Ringer's solution during the first three weeks.

The antirachitic factor was supplied entirely by the cod liver oil contained in the milk. At the time of these observations we had not yet had conclusive evidence of the efficacy of the antiscorbutic factor in this milk food. Hence, orange juice was administered to all our premature infants in the second week, starting with 1cc. and increasing 0.5 cc. daily until a total daily dosage of 15 cc. was reached. Iron in the form of saccharated ferrous carbonate (0.5 gram three times daily) was started during the second week. The infants were weighed three times weekly until they reached 3000 grams, and daily thereafter.

Blood calcium and phosphorus analyses and determinations of hemoglobin, red blood cells and reticulocytes were done monthly. Roentgenograms of the left wrist were taken weekly.

CRITERIA FOR THE VALUE OF A FOOD

The growth of the premature infant is the most important single criterion for judging its progress. Inasmuch as factors other than nutriment are equally important in obtaining optimum progress, it is difficult in a study of this kind to know how much significance to place on food alone. Therefore, in presenting our various criteria for the value of a food we do so with the realization that, although good nutriment is a very important factor in the successful rearing of premature infants, it is but one link in the chain of the other basic principles mentioned above which must be followed. We have, in consequence, used the several following criteria for the evaluation of our food: (1) cumulative gain in weight; (2) average daily rate of gain in weight; (3) muscle development and tissue turgor; (4) incidence of gastro-intestinal disturbances, their character and duration; (5) incidence of upper respiratory infections and their association with diarrhea; (6) incidence of rickets; (7) incidence of anemia; and (8) mortality rates.

Cumulative Gain and Rate of Gain in Weight—The traditional method of judging adequate gain in weight in premature infants has been to compare one's own results with those from other clinics, or with the normal gain of the full-term infant. Consequently, no fixed standards have thus far been maintained and no definite ideal curve has been recognized. The best gains that can be expected of premature infants are those which would have been maintained in intra-uterine life had not the accident of premature birth intervened. Reiche's[12] investigations have shown that the gain of premature infants follows the same rules that hold good for the corresponding months after impregnation. He claims that there is no difference between the intra-uterine and extra-uterine trend of gain in the same months, and that birth in itself causes no disturbance of growth in healthy premature infants. Wetzel[13, 14] has recently computed and described the trend of healthy human growth and gain from early fetal to adult life. The normally ante-natal portion of his curve as adjusted to the fetal data of Streeter[15] represents the course of growth and gain under ideal conditions of intra-uterine existence. This, accordingly, appears to us to be the best criterion of satisfactory progress among premature infants. Their comparative ability to maintain this standard trend of gain in weight will therefore serve as one of our important criteria of development and hence of nutritional success.

We have compared our data on gain both with Wetzel's standard and with results from other clinics. For purposes of accuracy we have kept separate our results on that group of infants which did not receive the milk food described during the early weeks of life. In Table 2 the average gain in weight per day in premature infants fed the milk from birth is shown for the respective weight groups over periods ranging from four to forty weeks. Column 5 shows the energy quotient after the third week of life. Table 3 shows similar data for those infants who entered the hospital from one to five weeks after birth and who did not receive the milk until that time. This group had the disadvantage of being reared during the early weeks—a vital period—in homes which were lacking in all the necessary facilities for the proper care of the infants. However, they responded well to hospital treatment and their average gain in weight over a long period of time does not differ significantly from the group which had hospital care from birth. The data in both tables reveal the higher average gains in the larger infants. With few exceptions, all our babies surpassed the average daily gain in weight for full-term infants over similar periods of time (about 20 grams). Hess[16] states that an average gain of from 10 to 15 grams for very small premature infants and from 15 to 20 grams for the larger ones may be considered satisfactory.

Table 4 shows the average daily gain in weight of premature infants reported by other observers. Our figures are well above the average. Since our infants gained extremely well in the later weeks, part of the reason for our high average can be accounted for by the longer period of observation. We believe, however, that the higher mineral, protein, and caloric intakes were more important factors in bringing about this result. The findings in Camerer's[17] group, which was observed for a period equally as long as ours and which represented an average gain of 4 grams less per day, approximately 20 per cent, appear to substantiate this interpretation.

TABLE 2.

AVERAGE GAIN IN WEIGHT PER DAY IN PREMATURE INFANTS FED PROTEIN S.M.A.* FROM BIRTH COMPARED WITH THEIR ENERGY QUOTIENTS IN CALORIES PER KILOGRAM PER DAY

Weight Groups	Case	Birth Weight	Weeks in Hospital	Energy Quotient after 3rd Week	Average Weight Gain per Day
		grams		cal./kg./day	grams
Under 1000 gms.	7140 M.W.	900	28	115 - 175	10.5
	Average Weight Gain per day for group: 10.5 grams				
1000 - 1500 gms.	2589 D.M.	1230	28	180 - 300	21.5
	4581 N.M.	1250	36	130 - 175	22.8
	4375 J.G.	1375	32	130 - 190	21.0
	4367 G.S.	1485	40	125 - 190	24.0
	Average Weight Gain per day for group: 22.3 grams				
1500 - 2000 gms.	4335 L.H.	1535	40	130 - 175	23.4
	2910 B.B.G.	1575	24	150 - 200	19.4
	4253 G.W.	1610	36	120 - 160	21.7
	4890 E.G.	1625	32	140 - 180	26.5
	4473 D.Y.	1700	36	135 - 195	17.0
	4947 P.M.	1740	4	120 - 140	15.5
	4837 R.H.	1750	36	125 - 170	22.0
	4147 T.H.	1800	8	120 - 180	27.6
	2809 B.B.W.	1800	32	160 - 230	19.1
	4720 D.P.	1810	32	130 - 180	24.7
	4350 D.H.	1900	32	125 - 185	18.1
	59 M.S.	1950	16	140 - 190	30.8
	Average Weight Gain per day for group: 22.2 grams				
2000 - 2500 gms.	4351 D.H.	2000	28	140 - 190	18.4
	4749 A.A.	2050	32	120 - 165	31.7
	5186 L.D.	2140	28	120 - 165	33.7
	4558 R.M.D.	2175	32	130 - 175	28.4
	4737 G.H.	2195	32	125 - 175	26.2
	Average Weight Gain per day for group: 27.7 grams				

*Plus additional carbohydrate according to method outlined in text.

Table 5 shows the time required to double, treble, and quadruple the birth weight of a series of premature infants where the necessary figures were available. There is no great difference between the figures of the respective groups. On an average, the birth weights were doubled in 13 to 14 weeks, trebled in about 22 weeks, and quadrupled in 25 to 30 weeks. Hess[16] states that a satisfactory average for doubling weight is 75 to 100 days (*i.e.*, 10½ to 14 weeks) in small premature infants and 50 to 100 days in the larger subjects. Camerer's[17] comparisons of breast and bottle fed premature infants are given in Table 6. It will be noted

TABLE 3.

AVERAGE GAIN IN WEIGHT PER DAY IN PREMATURE INFANTS FED PROTEIN S.M.A. BEGINNING WITH THE 2ND TO 5TH WEEK OF LIFE COMPARED WITH THEIR ENERGY QUOTIENTS IN CALORIES PER KILOGRAM PER DAY

Weight Groups	Case	Birth Weight	Weight at Beginning of P.S.M.A. Feeding	Weeks in Hospital	Energy Quotient after 3rd Week of Life	Average Weight Gain per Day
		grams	grams		cal./kg./day	grams
1000 - 1500 gms.	5224 J.B.	Unknown	1005	23	120 - 190	16.0
	3566 B.B.M.	1245	1325	28	120 - 195	16.7
	4407 V.W.	1380	2050	36	120 - 190	22.7
	Average Weight Gain per day for group: 18.4 grams					
1500 - 2000 gms.	2631 M.H.	Unknown	1550	28	106 - 220	17.0
	4692 L.L.	1500	2075	28	120 - 190	21.5
	4030 R.B.	1575	1570	20	135 - 180	28.7
	4866 E.H.	1575	1900	26	115 - 165	36.3
	4067 A.K.	1760	1750	18	125 - 175	23.9
	5616 N.M.	1800	1775	12	135 - 150	20.0
	5617 S.M.	1800	1710	12	135 - 180	20.1
	92 F.S.	1810	2000	16	125 - 200	23.6
	4015 I.K.	1920	1950	21	125 - 150	20.7
	4475 B.B.C.	1925	1575	11	120 - 170	17.8
	4748 A.A.	1945	1775	32	130 - 190	25.1
	Average Weight Gain per day for group: 23.2 grams					
2000 - 2500 gms.	3905 V.S.	2000	2050	8	130 - 200	16.8
	4838 M.N.	2025	1910	36	118 - 170	25.8
	4031 H.B.	2260	1975	20	135 - 160	24.4
	4443 E.O.	Unknown	1925	32	105 - 195	35.6
	4442 S.O.	Unknown	2150	32	105 - 165	32.0
	961 C.D.S.	Unknown	2075	3	140 - 150	33.4
	Average Weight Gain per day for group: 28.0 grams					

that, in respect to the time required to double and treble the birth weight, our figures closely parallel his results with breast-fed premature infants, and that they greatly exceed those of his group receiving artificial food.

In Chart 1 weight curves are given showing the composite mean gains of our respective groups comprising twenty-one premature infants who received the milk food from birth. Owing to the great changes in weight, the curves are placed on a semi-logarithmic scale. On the same chart are plotted the composite curves of the relatively larger weight groups of premature infants from the series of Hess and Chamberlain[18] fed human milk during the greater part of the period of observation. The curves show that our infants gained as well as the breast-fed infants in the weight groups 1000 to 1500 and 2000 to 2500 grams, and considerably better in the weight group 1500 to 2000 grams.

We have asserted that the best criterion for the satisfactory progress of the premature infant is its ability to traverse a course of gain in weight closely approximating the ideal weight as portrayed in the late ante-natal and

TABLE 4.

COMPARATIVE FIGURES SHOWING AVERAGE GAIN IN WEIGHT PER DAY IN PREMATURE INFANTS

Author	Weight Groups	Gain in Weight per Day	Duration of Observation Period
	grams	grams	weeks
Camerer	1330 - 1970	18.2 average	36
Poole and Cooley	over 1800	27.0 average	3 - 11
Hill (1925-26)	all weights	10.2 average	--
Hill (1927-28)	all weights	22.0 average	--
Hess and Chamberlain	1000 - 1500	23.6 maximum 15.8 average 14.6 minimum	12 21 16
Hess and Chamberlain	1500 - 2000	16.0 maximum 11.0 average 7.6 minimum	17 21 21
Hess and Chamberlain	2000 - 2500	26.1 maximum 17.8 average 17.2 minimum	9 18 15
Present Series	1000 - 1500 1500 - 2000 2000 - 2500	22.3 average 22.2 average 27.7 average	36 36 32

TABLE 5.

TIME REQUIRED TO DOUBLE, TRIPLE AND QUADRUPLE WEIGHT OF PREMATURES FED PROTEIN S.M.A.* FROM BIRTH

Weight Groups	Case	Birth Weight	Weight Doubled	Weight Tripled	Weight Quadrupled
		grams	weeks	weeks	weeks
Under 1000 gms.	7140 M.W.	900	14	25.5	---
1000 - 1500 gms.	2589 D.M.	1230	9.5	16.0	21.5
	4581 N.M.	1255	15.5	21.5	26.0
	4375 J.G.	1325	14.5	22.0	26.5
	4367 G.S.	1485	13.0	21.5	26.5
	Average for group:		13.1	20.2	25.1
1500 - 2000 gms.	4335 L.H.	1535	12.0	20.0	25.0
	2910 B.B.G.	1575	14.5	22.0	---
	4253 G.W.	1610	13.5	20.5	30.0
	4890 E.G.	1625	11.5	18.5	26.0
	4473 D.Y.	1700	16.0	23.5	---
	4837 R.H.	1750	16.0	23.0	33.5
	4147 T.H.	1800	9.5	---	---
	2809 B.B.W.	1800	16.5	28.5	---
	4720 D.P.	1810	12.0	19.5	30.0
	4350 D.H.	1900	19.0	29.0	---
	59 M.S.	1950	9.0	---	---
	Average for group:		13.6	22.7	28.9
2000 - 2500 gms.	4351 D.H.	2000	21.0	32.5	---
	4749 A.A.	2050	13.0	20.0	27.5
	4186 L.D.	2140	10.0	15.0	26.5
	4558 R.M.D.	2175	14.0	22.0	33.0
	4737 G.H.	2195	14.0	22.5	---
	Average for group:		14.4	22.4	29.0

*Plus additional carbohydrate according to method outlined in text.

CHART 1.

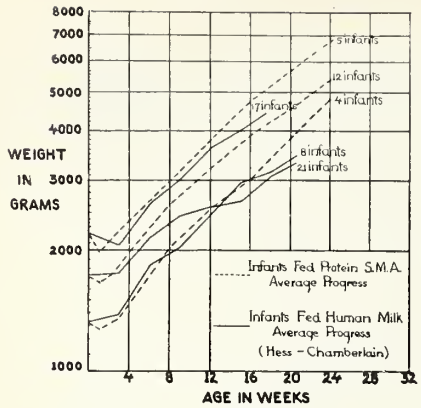


Chart 1.—Comparison of various weight curves of premature infants from series of Hess-Chamberlain and that of the authors.

early post-natal phases of Wetzel's standard weight curve.

Chart 2 shows a comparison of various weight curves with Wetzel's standard for the premature and early post-natal phase of life. We have also placed on this chart data from the reports of Blackfan and Yaglou[11], Camerer[17], and Hess and Chamberlain[18].

It is apparent at once that to obtain the optimum gains that occur during intra-uterine existence under the unfavorable conditions of extra-uterine life is a difficult task. It is also apparent that the smaller the premature, the more difficult this task becomes. That it can be accomplished is borne out by the results in our upper weight group (curve 1). This curve closely approximates the standard during the early premature phase, and oversteps it during the late premature and early post-natal phase. As the curves of other authors represent gains in subjects who were chiefly fed human milk, this observation again suggests the advisability of administering, in the case of premature infants, a food high in protein, minerals, and vitamins. Curve 7 in this chart shows the gain in weight of the smallest premature infant that we have had in our institution (see Table 2). He weighed 900 grams at birth and only 775 grams after his initial loss. He developed an infection early in life and his tolerance for food was low. Consequently his weight curve fell considerably short of the standard, and illustrates the greater difficulties encountered in the rearing of infants who are so small.

CHART 2.

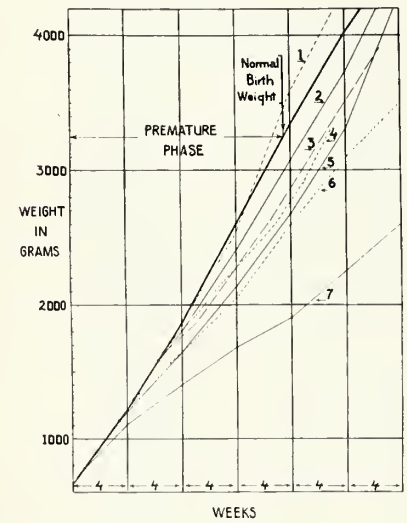


Chart 2.—Comparison of various weight curves with Wetzel's standard for premature phase of life. The numbered curves represent: (1) Authors' series, upper weight group (13 cases); median starting weight 2000 grams. (2) Authors' series, middle weight group (23 cases); mean starting weight 1595 grams. (3) Camerer's series (10 cases); mean starting weight 1630 grams. (4) Series of Blackfan-Yaglou, No. 3 group; mean starting weight 1725 grams. (5) Authors' series, lower weight group (6 cases); median starting weight 1140 grams. (6) Series of Hess-Chamberlain (8 cases), average progress; mean starting weight 1290 grams. (7) Patient 7140 in authors' series, the smallest premature cared for at the Babies and Childrens Hospital; starting weight 775 grams.

Muscle Development and Tissue Turgor—The premature infants in our series showed no tendency to develop flabby musculature or poor turgor. Toward the end of the third month, on an average, the skin sac became well filled out and the subcutaneous tissue firm. Our records during the later weeks of hospital observation state with monotonous regularity "turgor excellent." In the majority of our infants we have noted no particular delay in their ability to hold their heads erect, to sit up, or to make creeping movements. The photographs (Figs. 1a and 1b, 2a and 2b, 3a and 3b) show the state of nutrition (a) at the age of approximately one month and (b) at the

FIGURE 1a and 1 b.



Figure 1.—Patient 4749 A.A. (a) Age 3 weeks, weight 1975 grams. (b) Age 8½ months, weight 9390 grams. (The weight of the average full-term male infant of a corresponding age is generally given as 9000 grams.)

FIGURE 2a and 2 b.



Figure 2.—Patient 4890 E.G. (a) Age 1 month, weight 1950 grams. (b) Age 7 months, weight 7600 grams. (The weight of the average full-term female infant of a corresponding age is generally given as 7800 grams.)

FIGURE 3a and 3b.

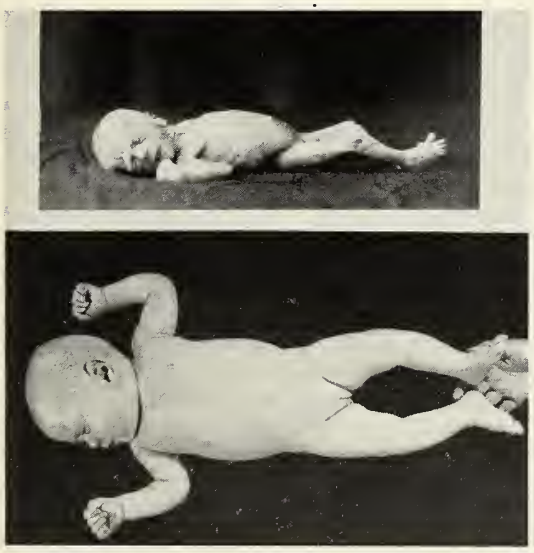


Figure 3.—Patient 4581 N.M. (a) Age 1 month, weight 1300 grams. (b) Age 7½ months, weight 6660 grams. (The weight of the average full-term female infant of a corresponding age is generally given as 8000 grams.)

time of discharge of three premature infants in our series.

Gastro-Intestinal Disturbances—The premature infant tends to develop disturbances of the gastro-intestinal tract. While many factors play a part in the causation of these disorders, such, for example, as lack of proper physiological development, infection, and failure to maintain equable body temperature or humidity, there are undoubtedly others, among them the quality of the

TABLE 6.

TIME REQUIRED TO DOUBLE, TREBLE AND QUADRUPLE WEIGHT IN PREMATURE INFANTS FED PROTEIN S.M.A. FROM BIRTH
Compared with Figures from Camerer

	Average Birth Weight	No. of Infants	Weight Doubled	Weight Trebled	Weight Quadrupled
	grams		weeks	weeks	weeks
Camerer's figures:					
Breast fed	1680	8	12	24	52
Artificially fed	2420	18	18	44 - 48	--
Authors' figures, Protein S.M.A.	1323	4	13.1	20.2	25.1
	1730	11	13.6	22.7	28.9
	2205	5	14.4	22.4	29.0

TABLE 7.

INCIDENCE AND DURATION OF GASTRO-INTESTINAL DISTURBANCES

Weight Groups	No. of Cases	No. of G.I. Upsets	Total No. of Infant Days	Duration of G.I. Upsets in Infant Days	Percentage of Time Free from G.I. Upsets
Under 1000 gms.	1	1	196	2	99
1000 - 1500 gms.	12	12	1624	91	94
1500 - 2000 gms.	27	15	4242	114	97
2000 - 2500 gms.	13	9	2135	60	97
ALL GROUPS	53	37	8197	267	97

food and the method of its administration, which play a still greater role in helping to prevent gastro-intestinal disturbances. The incidence of these upsets, their duration, and their association or lack of association with infections were carefully studied. Diarrhea or vomiting sufficient in degree to cause loss in weight or failure to gain was regarded as a digestive disturbance. The duration of these attacks is obviously of greater significance than their actual incidence. Column 6 of Table 7 gives the proportion of time during which our infants were free from these disturbances. This percentage is high, varying in the four weight groups from 94 to 99 per cent and averaging 97 per cent for all groups over a period of 8197 infant days.

Most of the gastro-intestinal disturbances were accompanied by parenteral infection (Table 8). This is true of 80 per cent of the upsets in the weight group 1000 to 1500 grams, of 60 per cent in the 1500 to 2000 group, and of 67 per cent in the 2000 to 2500 group. The infections were

TABLE 8.

ANALYSIS OF GASTRO-INTESTINAL DISTURBANCES

Weight Groups	No. of Cases	Total No. of G.I. Upsets	Nutritional Disturbances	Enteritis Follicularis	Parenteral Dyspepsia	
					No.	%
Under 1000 gms.	1	1	1	0	0	0
1000 - 1500 gms.	12	12	2	0	10	80
1500 - 2000 gms.	27	15	5	1	9	60
2000 - 2500 gms.	13	9	3	0	6	67
ALL GROUPS	53	37	11	1	25	67

chiefly those located in the upper respiratory tract. For all groups 67 per cent of the gastro-intestinal disturbances were accompanied by infection, the so-called parenteral dyspepsia. The disturbances unaccompanied by infection, that is, the so-called nutritional disturbances, had a duration varying from two to fifteen days per infant, a total duration for the group of 107 infant days,

TABLE 9.

INCIDENCE AND DURATION OF UPPER RESPIRATORY INFECTIONS

Weight Groups	No. of Cases	No. of Infections	Total No. of Infant Days	Duration of Infections in Infant Days	Percentage of Time Free from Infection
Under 1000 gms.	1	0	196	0	100
1000 - 1500 gms.	12	20	1624	131	92
1500 - 2000 gms.	27	47	4242	291	93
2000 - 2500 gms.	13	20	2135	87	96
ALL GROUPS	53	87	8197	509	94

TABLE 10.

ASSOCIATION OF UPPER RESPIRATORY INFECTION WITH DIARRHEA

Weight Groups	No. of Cases	No. of Infections	No. of Infections with Diarrhea	Percentage of Infections with Diarrhea
Under 1000 gms.	1	0	-	--
1000 - 1500 gms.	12	20	9	45
1500 - 2000 gms.	27	47	5	11
2000 - 2500 gms.	13	20	5	25
ALL GROUPS	53	87	19	22

and thus accounted for only 1.4 per cent of the total hospital stay. It is therefore clear that these infants were free from purely nutritional disturbances during 98.6 per cent of their period of observation.

Incidence of Respiratory Infections—That the premature infant possesses a low grade of immunity to infection, especially with regard to the respiratory tract, has long been known. A special premature nursery out of contact with sick infants is therefore of great advantage in diminishing the incidence of these infections. Since we did not possess this advantage, it was necessary to care for all of our premature infants on an infant ward of twelve beds. We did try, however, to keep to a minimum the number of sick infants in these wards. In addition, the infants were placed in individual cubicles and strict isolation technic was maintained at all times.

Table 9 shows the incidence and duration of upper respiratory infections. Although the incidence is high, the severity of the infections, as judged by their duration, is relatively slight, for the entire group of infants was actually free from respiratory infections 94 per cent of the time.

The association of diarrhea with upper respiratory infections is shown in Table 10. In view of the ease with which respiratory infection causes disturbances of the gastro-intestinal tract in infants, we should ordinarily expect that the incidence of gastro-intestinal disturbances in this group would be rather high, but, as the table shows, only 19 infections, of a total of 87, were accompanied by diarrhea. This, we believe, signifies that the milk food described is very well tolerated even during those periods when tolerance for food in general is widely recognized to be low.

Prevention of Rickets—Our infants received the antirachitic factor as a constituent part of the milk in amounts varying from 0.8 cc. to 4 cc. of cod liver oil daily, depending upon the quantity of food ingested. Roentgenograms of the wrist were taken weekly and blood calcium and phosphorus determinations were done monthly, and occasionally semimonthly. None of these infants developed rickets as revealed by normal roentgenograms, normal blood calcium and phosphorus values and by the absence of definite clinical signs. Our complete data on this subject will be presented in another publication. Table 11 shows the data on three representative cases for the respective weight groups.

Incidence of Anemia—Our studies in anemia will be presented in detail in another publication. It is sufficient to say that the majority of our infants developed the usual physiological anemia of prematures in spite of the early administration of large doses of iron.

Mortality Rates—The greatest number of deaths in premature infants occur during the first forty-eight hours after admission. Immature structural development causes most of them, but other conditions prior to the entry to the hospital also play a part, according to the opinion of many investigators. Hess[19] showed that a definite relation exists between the mortality rate and the admission temperature, and he therefore devised a heated carrier for use in the ambulance. Studies by Clifford[20] suggest a possible relationship between mortality rate and mode of delivery. For these reasons we have excluded from our statistics such deaths as occurred within the first forty-eight hours after admission. These were obviously due, for the most part, to conditions beyond our control. Of the fifty-three subjects given the milk food, eleven died,—a percentage mortality of 20.7 (see Table 12). The highest mortality occurred in the 1000 to 1500 gram weight group. In this group three of the deaths were classed as unavoidable because the infants entered the hospital acutely ill. Exclud-

ing deaths within the first forty-eight hours as well as unavoidable deaths, the mortality rate for our entire series of infants turns out to be 15 per cent.

COMMENT

We wish to make it clear that, even though our results in this series have been very satisfactory and in many instances surpass the results obtained in other clinics in premature infants fed human milk, we are not necessarily advocating the use of artificial food in preference to human milk for premature infants. That question we are not attempting to answer at this time. We merely feel justified from the data presented in stating that when human milk is not available for the premature infant, the milk food mixture used by us makes an excellent substitute. That the relatively high protein content of this milk is one of the factors responsible for its adaptability to the premature infant, we believe to be certain. Gerstenberger has been of the opinion for many years that human milk when fed to premature infants should be reinforced by the addition of powdered skim milk. Consequently, when a food suited to the premature infant was devised[7, 8], its protein content was made two and a half to three times greater than that of human milk. Another factor that we believe to be of importance in explaining the efficacy of this milk is the high mineral and vitamin content which enables the administration of a liberally adequate amount of these essential food constituents without increasing the quantity of the food above that usually taken in the form of human milk. Further, we hope that we have also emphasized sufficiently the importance of the other basic principles which must be followed for the successful rearing of these infants. We hope, too, that we have stressed sufficiently the value of adopting a universal standard by which the progress of these infants may be judged. We believe that the simplest and yet the most accurate method of accomplishing this is to compare the clinical trend in weight with the corresponding portion of Wetzel's curve for the premature phase of life. An example of this type of comparison has already been given in connection with the curve shown in Chart 2.

SUMMARY AND CONCLUSIONS

1. A report is made on the experiences obtained in the feeding of 53 premature infants. Of these, 11 died and the remainder received at the hospital for an average of six months one and the same milk food,* 22 from birth and 20 from the age of approximately two to five weeks.

2. The milk food used was a powdered acid protein milk similar to casein and lactic acid milks, and had a pH of 4.6. The acidity of this food is obtained by adding 20 cc. of lemon juice to a milk in which lactic acid has been produced by controlled bacterial fermentation. One-fifth of the acidity is due to the citric acid added in the form of lemon juice and four-fifths to lactic acid. The lemon juice provides the antiscorbutic factor which has been found adequate for the cure of scurvy in infants. The fat of the milk is a mixture of animal and vegetable fats, including biologically tested cod liver oil, and has character numbers that are practically identical with those

TABLE 11.

PREVENTION OF RICKETS IN PREMATURE INFANTS FED PROTEIN S.M.A.

Month of Life	Case 4367 G.S. Birth Weight 1485 gms. Representetive of Weight Group 1000-1500 gms.				Case 4253 G.W. Birth Weight 1610 gms. Representative of Weight Group 1500-2000 gms.				Case 4749 A.A. Birth Weight 2050 gms. Representative of Weight Group 2000-2500 gms.			
	Serum Ca	Serum P	X-Ray Left Wrist	Average Amount of C.L.O. Daily	Serum Ca	Serum P	X-Ray Left Wrist	Average Amount of C.L.O. Daily	Serum Ca	Serum P	X-Ray Left Wrist	Average Amount of C.L.O. Daily
	mg.	mg.		cc.	mg.	mg.		cc.	mg.	mg.		cc.
1st	--	--	--	0.8	--	--	--	0.9	12.0	6.0	--	1.1
2nd	9.6	7.1	Normal	1.4	9.8	5.3	Normal	1.1	--	--	Normal	1.6
3rd	10.6	6.8	"	1.8	10.6	6.7	"	1.6	10.4	5.9	"	1.6
4th	11.0	6.0	"	2:2	11.5	6.2	"	2.4	10.2	5.7	"	2.6
5th	10.4	5.5	"	2.7	10.9	5.9	"	2.7	10.2	5.9	"	3.0
6th	11.3	5.9	"	3.6	11.2	6.5	"	3.6	10.9	6.1	"	4.0
7th	11.0	4.1	"	4.0	12.3	5.6	"	4.0	11.0	5.9	"	4.0
8th	10.8	5.6	"	4.0	10.4	5.6	"	4.0	10.1	6.0	"	4.0
9th	11.4	5.9	"	4.0	--	--	--	--	--	--	--	--

TABLE 12.

MORTALITY ACCORDING TO WEIGHT ON ADMISSION OF PREMATURE INFANTS FED PROTEIN S.M.A.

(Infants dying within 48 hrs. after admission excluded)

Weight Groups	No. of Cases	No. of Deaths	Mortality	No. of Unavoidable Deaths	Mortality Excluding Unavoidable Deaths
			per cent		per cent
Under 1000 gms.	1	0	0	0	0.0
1000 - 1500 gms.	12	5	41.7	3	16.6
1500 - 2000 gms.	27	4	14.8	0	14.8
2000 - 2500 gms.	13	2	13.3	0	13.3
ALL GROUPS	53	11	20.7	3	15.0

* Protein S.M.A. (Acidulated).

of human milk. The cod liver oil content of the milk is 3.8 cc. per quart and the approximate analysis, when the milk is diluted according to directions, is as follows:

Protein	3.5
Fat	2.2
Carbohydrate	2.8
Ash	0.6
pH	4.6
Calories per ounce	15
Calories per 100 cc	50

Carbohydrate, in the form of corn syrup, was added as deemed necessary to meet the carbohydrate and caloric requirements of the individual infants. Orange juice was administered in the second week, starting with a dose of 1 cc. daily and reaching a maximum dose of 15 cc. daily in the sixth week. Saccharated ferrous carbonate in a dose of 0.5 gram three times daily was started by the second week.

3. The results obtained were evaluated according to the following criteria:

(a) Cumulative gain in weight.

(b) Average daily rate of gain in weight.

(c) Muscle development and tissue turgor.

(d) Incidence of gastro-intestinal disturbances, their character and duration.

(e) Incidence of upper respiratory infections and their association with diarrhea.

(f) Incidence of rickets.

(g) Incidence of anemia.

(h) Mortality rates.

4. The results were as follows: (a) The infants showed an excellent gain in weight and approximated closely the ideal weight as portrayed in Wetzel's standard curve.

(b) The average daily rate of gain in weight was equal to and in many instances surpassed the average daily rate of gain of premature infants in the series of other observers.

(c) Excellent muscle development and tissue turgor was found in all cases.

(d) The incidence of gastro-intestinal disturbances of the so-called nutritional type was low and their duration was brief, the infants being free from purely nutritional disturbances during 98.6 per cent of their period of observation.

(e) While the incidence of respiratory infections was relatively high, their severity as judged by their duration was mild, the entire group of infants being actually free from respiratory infections 94 per cent of the time.

(f) Rickets was prevented in each instance as judged by weekly roentgenograms of the wrist and by monthly determinations of the blood serum calcium and inorganic phosphate.

(g) The physiological anemia of premature infants was not prevented by the liberal administration of saccharated ferrous carbonate.

(h) The mortality rate was 15 per cent.

5. The results obtained clearly indicate that the milk food* described possesses certain distinct qualities that make it a particularly valuable food for the rearing of premature infants. These qualities in our opinion are its high protein, high mineral, high vitamin and reduced fat content.

* Protein S.M.A. (Acidulated).

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OBSERVATIONS IN THE USE OF IRRADIATED BLOOD IN CONNECTION WITH CANCER

By BURTON E. HYDE, M.D.,

TROY, OHIO

FOREWORD

In presenting this preliminary report it is the endeavor of the author to give only the results of his observations and findings during a period of the past four years devoted to research in Cancer.

IT has long been known that *X*-ray has a damaging effect on cancer cells, and it is conceivable that it may act to produce some effect on the media in which those cancer cells exist. With this in view we have made an attempt to irradiate one of these media. In the living only the blood can be so treated.

THE STUDY AND THE RESULTS

The first study was made on a man sixty-four years old, who one year before was operated upon for an alleged "adenomatous" prostate. The usual two-stage method was followed. The suprapubic incision failed to heal, and an attempt was made to close the draining sinus, or at least insert a cystotomy tube. At this operation it was not possible to enter the bladder, due to a hard mass which practically filled the bladder. A biopsy showed cancer. For a period of three months irradiated blood was given every five days. Then a second operation was performed, and it was found that the large mass had disappeared and only a small hickory nut sized tumor remained. A biopsy of this again showed cancer. This man lived free from pain for two years, during which time he had treatments on the average of once every six weeks. He died of pneumonia, and at postmortem the bladder showed no recurrence of carcinoma.

TYPE OF CASES

The result obtained in this first case seemed to warrant further trial of the method. At first only patients who had had a pathological diagnosis were treated. These early cases were obviously seen late in the disease, and some of them were in a hopeless condition. They were in pain. Some had had considerable treatment with radium and *X*-ray. In these late cases I observed that after one or two treatments they were more comfortable, their appetite increased, and the pain diminished. The lessening of pain was very striking. The results appeared to be unaffected by radium or *X*-ray.

The next patients treated were the so-called surgically inoperable ones. The results were encouraging. Many of these cases have gone over a period of two years without any evidence of recurrence following incomplete operation. They have been free from pain, able to do their work, and enjoy life. At the present time I treat these cases first for a period of at least three weeks and then operate, and then continue with the treatment.

I have had cases of carcinoma of almost every part of the body. Certain cancers respond to treatment sooner than others. Carcinoma of the urinary bladder responds very quickly; the uterus also reacts rapidly to treatment. Carcinomas of the face and neck are slow to respond. There seems to be no clear difference according to the age of the patient. The younger patient does not respond any sooner than an older patient, but the longer standing the carcinoma, the more resultant it is to treatment.

THE METHOD OF TREATMENT

The whole blood is drawn from the arm vein into a container to which sodium citrate has been added. This is then exposed to the quartz mercury vapor lamp, and to *X*-ray. This blood is injected into the arm vein, always using the same blood from the same patient—autogenous blood. If that patient has a malignant condition, there will be *no* reaction. If that patient does *not* have a malignant condition, then in about five minutes there will be a reaction, starting with a chill and lasting about twenty minutes, and followed by a fever. There are no ill effects except that the patient is rather uncomfortable from the reaction. If blood of the same group is taken from a "non-cancer" patient and after treatment given to a "cancer" patient, then that "cancer" patient will get a reaction.

The patient receives these blood injections every five to seven days until a reaction takes place. Apparently this reaction in the "cancer" patient after a certain number of treatments occurs at a time when the cancer is not active. After the reaction treatment is suspended, usually for one month. If then a reaction is produced, I wait three months, and then if there is a reaction, wait six months. This is followed with an injection every six months.

The above routine is followed in case of a reaction after each treatment. If after a month's rest there is no reaction, then I go back to every five days again until I do get a reaction. A wait-

Spectroscopic Work by W. R. Koch, A. B., M. A., Dayton, Ohio.

ing period follows. The idea is to keep that condition under control.

APPARENT EFFECTS OF TREATMENT

Carcinoma on the surface with extensive ulcerations—Within a few hours the odor is gone, the pain starts to lessen in about twenty-four hours, and the patient feels better. In cases of uterine cancer with bleeding there is lessening of the bleeding in from ten to twelve hours. In all cancers where pain is not due to mechanical pressure there is less pain, an increase in appetite, and retrogression of the growth. Relief of pain is the outstanding effect in all of the cases.

Where the cancer is visible—skin, cervix, rectum, or mouth, a lessening of secondary infection and a tendency to slough is seen. The bleeding from these lesions is slight, except when a slough occurs.

The blood picture shows a slow increase in hemoglobin content. This may be due to the general well-being with better appetite and less bleeding. Six hours after the treatment there is a decrease in the white count, usually between 1,000 and 1,500. At the end of twenty-four hours the count has returned to that present before the blood was injected. No change is noticed in the platelets. As the blood is taken from the vein, we have observed in those cases where a reaction is near, that the blood appears of a brighter color. Also after the blood is treated it appears to be a brighter red than before treatment. This change does not appear after the quartz lamp exposure, but only after the *X*-ray has also been used.

DISCUSSION OF THE REACTION

We wish now to discuss the observation that the non-malignant case gets a reaction—chills and fever—and the malignant does not. We may entertain two lines of thought on this point. First, a chemical change has taken place, as between the normal blood and the "cancer" blood as a result of treatment. Second, what is that change, and what causes it? This may hold the secret of cancer. If there is a change, there must be a time when that change first appears. Is it a change that accompanies cancer, a metabolic substance that it gives off by cancer, or is it a change that has to be present before cancer appears? In a hypothetical case of cancer on the back of the hand the patient presents himself with an ulcerated area about the size of a silver dollar and a pathological diagnosis that was reported as "cancer". He has had surgical treatment by excision and cauterization followed by *X*-ray and possibly radium. He is free from trouble for a time, and then gets a recurrence. The accepted view is that it recurred because some cells were left behind. Recurrence in spite of treatment suggests an additional factor. If there is a factor that has to be present to allow the development of cancer cells, then removal of that cancer followed by the destruction of that factor may be more successful in producing cure.

The above theory may be used as a working hypothesis. The observation that the normal or non-malignant case gets a reaction after the blood is injected, and that the "cancer case" does *not* get a reaction suggests that the effect of irradiation on these bloods is a chemical one. We must next demonstrate that change has in fact occurred. This has been done by the use of the spectroscope. Blood treated as described later, and subjected to spectroscopic examination shows a difference that may indicate whether cancer is present, or, after operation, if that "factor" that is present in the blood, is active or not. We think that this "factor" must be present before cancer can exist. Therefore it is probably not a metabolic change, but a definite substance, *or the lack* of a definite substance in the "cancer" blood. The demonstration of this "factor" suggests that cancer is due to a general, rather than a local change. The cancer cell has the character of the tissue from which it arises, which suggests that cancer is related to that tissue not foreign.

The findings presented later in this paper in regard to the spectroscopic work point to the possibility that cancer is a deficiency condition. This suggests three possibilities in the handling of the cancer problem. First, a cure, which I think is unlikely. Second, a control, which to date looks possible. Third, prevention. From the clinical side and from experiments on human blood, I think that there is a definite chemical condition which is a prerequisite to the development of cancer. Cancer can only get its food supply from the blood and the active condition can only be carried by the blood. Therefore, the blood should show some characteristics not present in other diseases.

RECORD OF THE SPECTROSCOPIC WORK

By Wendell Koch, A.B., M.A.

In an attempt to distinguish blood from cancer patients from those of normal individuals, their absorption spectra were photographed in the visible and ultra-violet regions. In order to estimate the relative absorption of the various samples, the fluids were placed in glass cells having crystal quartz windows. The cell containing the fluid was placed before the slit of a quartz spectograph illuminated by a two ampere iron arc. The focal length of the spectrograph is 170 centimeters and the region covered by these spectrograms extends from a wave length of 240 millimicrons to the red limit of the panchromatic plates used which is approximately 670 millimicrons.

Three exposures were made for each sample. The length of the exposures were 5 seconds, 50 seconds and 500 seconds. The first group of three spectra on each plate is a similar series of exposures for the direct radiation from the iron arc.

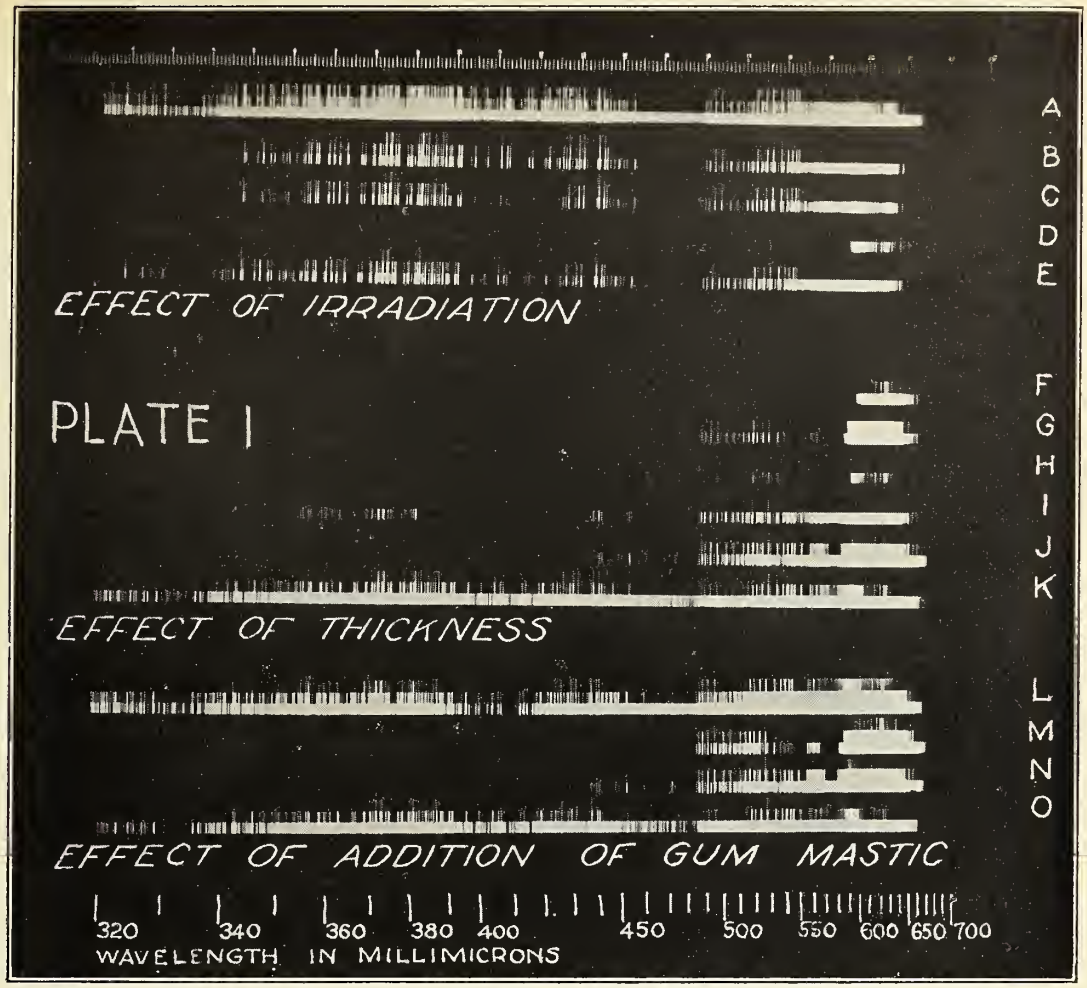


Plate 1. Significant Factors Affecting Spectral Absorption.

The effects of several of the most significant factors affecting spectral absorption, are shown in Plate 1. The group of spectra marked A is due to the direct radiation of a two ampere iron arc and may be used for comparison. The region covered in this plate extends from 320 millimicrons to the red limit. None of the samples studied showed any appreciable transmission in the region between 240 millimicrons and 310 millimicrons. In general the samples were irradiated with certain wave lengths before haemolysis. Following the addition of saponin and the resulting haemolysis a solution of gum mastic in alcohol was added to the samples in most cases. Before the spectrograms were made the solutions were filtered.

The effect of the irradiation on normal bloods is quite striking. Spectrum B is that transmitted by a normal blood which was not irradiated, but which had been haemolyzed and had received the addition of gum mastic. Spectrum C is that transmitted by blood from a case of carcinoma which had undergone the same treatment as the normal blood of spectrum B. It may be concluded that spectra B and C are not readily distinguishable.

Spectrum D is that transmitted by a normal blood which had been irradiated prior to the haemolysis and gum mastic addition described for spectrum B. The bloods for spectra B and D were taken from the same normal individual and differed only in the matter of irradiation to ultra-violet and *X*-rays. The capacity of the irradiated blood to the violet and ultra-violet regions is apparent.

Spectrum E is that transmitted by blood from a case of carcinoma which had been irradiated and treated in the same manner as the normal blood shown in spectrum D. The bloods for spectra C and E were taken from the same case of carcinoma and differed only in the matter of irradiation.

Since no radical change in absorption occurs upon irradiation of blood from cancer, we now have a marked distinction between spectra D and E, which represent a normal and a malignancy, respectively. These two bloods underwent the

same irradiation, haemolysis, gum mastic addition, and filtration. The contrast between spectra D and E, based on the ultra-violet capacity of irradiated normal bloods, is the fundamental criterion developed by these spectral absorption measurements.

Spectra B, C, D and E were transmitted by a ten millimeter thickness of sample. Under these experimental conditions we may thus divide our samples into two groups; the members of the first group being opaque to radiation of wave length less than 485 millimicrons while members of the second group are relatively transparent to violet and ultra-violet radiation, except for an absorption band whose wave length is approximately 404 millimicrons. Visual spectrophotometric measurements were made on some of the samples but it was concluded that much more significant differences were apparent in the ultra-violet region.

The irradiation of the samples referred to above, consisted of twenty minutes exposure to an ultra-violet source followed by ten minutes exposure to an *X*-ray source. Variation in the time of ultra-violet exposure was studied. It was found that an increase in the exposure time did not produce any appreciable change in the absorption of solutions which did not contain the gum mastic addition. No effect of increase in exposure time was detected in malignant bloods which did contain the gum mastic addition, except in the case of general carcinomatosis. Although as yet only a few cases have been investigated, it appears that bloods from cases of general carcinomatosis show the characteristic absorption of normal bloods after twenty minutes exposure to ultra-violet radiation and subsequent exposure to *X*-rays, haemolysis, gum mastic addition, and filtration. However after thirty minutes exposure to ultra-violet radiation and the same subsequent treatment as before, the absorption spectrum of a case of carcinomatosis is characteristic of malignant blood—being transparent to the ultra-violet region.

The effect of the thickness of the absorbing blood solution was investigated. During all of the tests the concentration of the blood solution examined relative to the original blood sample was kept constant; that is, dilutions and additions were volumetrically equal from sample to sample. The details of this procedure will be discussed in relation to Plate 2. By a study of the thickness of the absorbing medium it was found that a thickness of ten millimeters exhibited a readily observed distinction between normal and malignant bloods. In Plate 1 spectra F and G represent thirty millimeter thicknesses of a normal blood and a carcinoma blood, respectively. Spectra H and I represent ten millimeter thicknesses of a normal blood and a carcinoma blood, respectively. Spectra J and K represent five millimeter thicknesses of a normal blood and a carcinoma blood, respectively. This series of spectra indicates that comparisons are only valid, when the concentration, absorbing thickness, intensity of source and time of exposure are constant from sample to sample.

The effect of the addition of an alcoholic solution of gum mastic to the irradiated and haemolyzed blood samples is shown in Plate 1. Spectrum L is that transmitted by a normal blood which had been irradiated, haemolyzed, and filtered, but to which no gum mastic had been added. Spectrum M is that transmitted by a carcinoma blood which had been irradiated, haemolyzed, and filtered, but to which no gum mastic had been added. Spectrum N is that transmitted by a normal blood which had been irradiated, haemolyzed, and had received the addition of gum mastic. Spectrum O is that transmitted by a carcinoma blood which had been irradiated, haemolyzed, and had received the addition of gum mastic. Spectra L and N were due to blood from the same normal individual while spectra M and O were due to blood from the same case of carcinoma.

Spectra L, M, N and O were transmitted by a five millimeter thickness of sample. Since the alcoholic solution of gum mastic is transparent to the ultra-violet region, no satisfactory explanation of the increase in absorption for normal blood has been found.

It may be observed that the malignancies are much more opaque if the gum mastic addition after haemolysis is omitted while normals do not appear to be appreciably altered by this omission. The increase in ultra-violet transmission for malignant bloods may be due to the flocculation or precipitation of some constituent which absorbs ultra-violet radiation. The alcoholic solution of gum mastic is transparent to the ultra-violet region.

The procedure finally adopted was based on an original sample of twenty cubic centimeters of blood. The sample was added to five cubic centimeters of 2 per cent sodium citrate and shaken. This solution was placed in a porcelain evaporating dish and exposed to a quartz mercury arc at a distance of eighteen inches for a period of twenty minutes. The *X*-ray exposure was made at a distance of ten inches from the tungsten target tube operating at 90,000 volts with a current of five milliamperes. One cubic centimeter of the irradiated blood was diluted with ten cubic centimeters of distilled water. A very minute amount of saponin was added in order to haemolyze the blood. After adding five cubic centimeters of a saturated solution of gum mastic in alcohol to the diluted portion, the specimen was shaken thoroughly and the solid matter allowed to settle for several hours. Following filtration of this solution it was placed in a glass cell having

crystal quartz windows ten millimeters apart. The exposures to the two ampere iron arc were made through this cell for periods of five seconds, fifty seconds, and five seconds.

In this spectrographic investigation seventy spectra were photographed through bloods from thirty-four individuals. After various factors had been studied and the procedure outlined in the above paragraph had been selected, the thirty-eight spectra shown in Plate 2 were photographed according to that procedure. None of the spectra obtained by this method have been omitted. Spectra 18 and 25 are of blood from the same individual. This is also true for spectra 19 and 30, and for spectra 31 and 35.

Spectrum 1 is that of the direct radiation of the iron arc.

Spectrum 2 is that of a normal blood which shows absorption in the ultra-violet region.

Spectrum 3 is that of a case of carcinoma which is relatively transparent to the ultra-violet region.

Spectrum 4 is that of a case of carcinoma.

Spectrum 5 is that from a case of leukemia.

Spectrum 6 is that of a case of carcinoma.

Spectrum 7 is that of a normal blood.

Spectrum 8 is that of a case of carcinoma.

Spectrum 9 is that of a case of sarcoma.

Spectrum 10 is that of a case of carcinoma.

Spectrum 11 is that of a normal blood.

Spectrum 12 is that of a normal blood.

Spectrum 13 is that of a case of carcinoma which does not show the ultra-violet absorption usually associated with malignant blood. This case had been treated and at the time the sample was taken was in such a condition that a reaction was obtained after intravenous injection of irradiated blood. It appears that the occurrence of the reaction on injection is well correlated with the ultra-violet transparency.

Spectrum 14 is that of a normal blood.

Spectrum 15 is that of a case of carcinoma. The absorption band at approximately 404 millimicrons does not appear in this spectrum.

Spectrum 16 is that of a case of carcinoma.

Spectrum 17 is that of a case of carcinoma.

Spectrum 18 is that of a case of carcinoma which is also shown in Spectrum 25.

Spectrum 19 is that of a case of carcinoma which is also shown in Spectrum 30.

Spectrum 20 is that of a case of carcinoma.

Spectrum 21 is that of a case of carcinomatosis. This spectrum does not exhibit the ultra-violet transparency usually associated with malignant blood. However, when a sample of blood from this same individual was irradiated with ultra-violet for thirty minutes and then treated in the usual manner, it was found that the absorption spectrum showed the usual transparency of a malignant blood to ultra-violet radiation.

Spectrum 22 is that of a case of carcinoma.

Spectrum 23 is that of a patient having a "tumor". The absorption is similar to that of a normal individual.

Spectrum 24 is that of a normal blood.

Spectrum 25 is that of the patient whose blood is shown in Spectrum 18 after he had been treated and after the cancer had disappeared. The absorption is similar to that of a normal individual.

Spectrum 26 is that of a case of tuberculosis. Although the blood is relatively transparent in the violet region, the transmission in the ultra-violet region is very low compared to that of malignant bloods.

Spectrum 27 is that of a case of carcinoma. On the original plate a faint image of the spectrum could be followed as far as a wave length of 340 millimicrons, but it must be admitted that no satisfactory distinction exists between spectra 26 and 27.

Spectrum 28 is that of a normal blood.

Spectrum 29 is that of a case of carcinomatosis. This spectrum shows the ultra-violet absorption usually associated with normal bloods. It is possible that the prolonged irradiation given to the blood in spectrum 21, would have changed the absorption. In this case it was not investigated.

Spectrum 30 is that of the blood from the same individual as that of Spectrum 19. In the interim this case of carcinoma received considerable treatment.

Spectrum 31 is that of a case of carcinoma which is also shown in Spectrum 35.

Spectrum 32 is that of a normal blood.

Spectrum 33 is that of a patient who suffered a skull fracture.

Spectrum 34 is that of a case of carcinomatosis. This spectrum shows the ultra-violet absorption usually associated with normal bloods. It is possible that the prolonged irradiation given to the blood in Spectrum 31 would have changed the absorption. In this case it was not investigated.

Spectrum 35 is that of the blood from the same individual as that of Spectrum 31 after the malignancy had been removed surgically.

Spectrum 36 is that of a case of tuberculosis.

Spectrum 37 is that of a case of benign tumor.

Spectrum 38 is that of a case of syphillis.

From the clinical side as a result of the spectroscopic findings, we get the suggestion that we have a possibly reliable blood test for cancer, or more important, of potential cancer. These spectra are not of picked cases. They are taken from routine work.

The next suggestion is that this is not specific for any one type or group of cancers.

Finally, the spectroscopic evidence seems pretty definite.

We show with these spectra that these findings are definitely quantitative.

The addition of Saponin and the gum mastic no doubt plays some part. The precipitate in the "cancer" blood brings the coloring matter (hemoglobin) with it, while in the normal or non-cancer bloods this does not happen, suggesting chemical difference brought about by the action of the radiation.

CLINICAL ASPECTS OF SPECTRA

The value of these spectra is enhanced by the fact that the observations were made by an unprejudiced observer who could identify the bloods only by number.

Plate No. 2, Spectrum No. 3.—This is from the blood of a woman fifty-three years old, who four years ago was operated upon for extensive carcinoma of the bowel at one of the largest and best known clinics in the Middle West. During the past four years she has had extensive *X*-ray therapy and a thorough check-up from the clinical

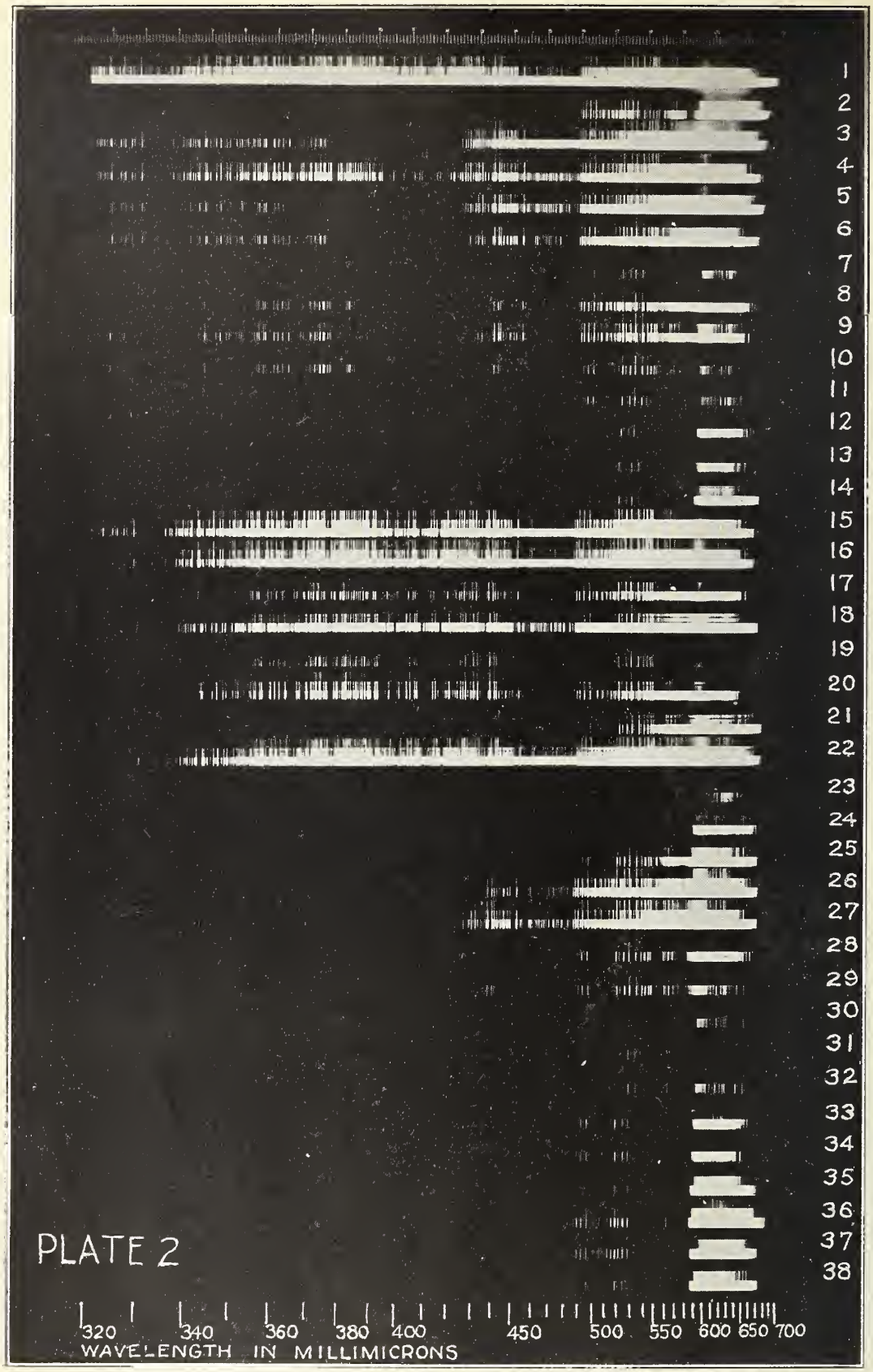


Plate 2. Spectral Absorption of Irradiated Blood Samples.

side with no evidence of recurrence. Yet the spectrum of her blood indicates that this "factor" we have been talking about, is present. After eighteen injections she obtained a reaction. During this time she has picked up twenty pounds in weight and states she feels better than ever.

Plate No. 2, Spectrum No. 6.—This is from the blood of a woman sixty-four years old. When first seen there was a huge ulcerative carcinoma of the right side of the face, involving the mandible. Ten hours after the first injection she noticed a complete disappearance of the odor. After the third injection only a quarter grain of morphine was required at night for sleep, whereas before she required one quarter grain every three hours. She was kept alive comfortably for six months, but during the last forty-eight hours had much pain. This "end pain" during the past thirty-six hours is constant.

Plate No. 2, Spectrum No. 13.—This is from the blood of a woman age twenty-four years with far advanced adenocarcinoma of the uterus and urinary bladder. Operation consisted of a partial hysterectomy and extensive cauterization of the cervix. The cervix was attached to the bladder, and complete hysterectomy was not done for fear of urinary fistula. Blood spectrum was taken on the blood that gave the patient a reaction. She died two years later from uterine hemorrhage, following a large slough.

Plate No. 2, Spectrum No. 15.—This is from the blood of a forty-five year old man with cancer of the external ear, extending over the top of the external ear and on to the side of the face for one inch. Under treatment by irradiated blood injections, the face was healed completely without a scar. The ear healed except a small area one-quarter by three-quarters inch, covered by a scab. He was under my care for six months, then was forced to go to an institution for the poor. *X*-ray treatments were carried out, and were followed by an extensive spreading of the carcinoma. A complete removal of the external ear was done. I have no further report since.

Plate No. 2, Spectra Nos. 18 and 25.—(No. 18 the first blood that was taken from this patient.) The patient was a man, fifty-eight years old, who thirty-five years ago was vaccinated for smallpox, which resulted in an infectious granuloma. For thirty-five years this man wore a dressing. The lesion was removed five times during this period, three times by cautery, twice by surgery. He had been treated by *X*-ray. I first saw this patient in July, 1933. At this time he complained of numbness and some pain in the left arm and hand. An ulcerative area the size of a silver dollar over a raised mass with rolled out edges was present on the left upper arm. There was no evidence of glandular involvement in the axilla. He was given an injection once a week until the middle of December, 1933, with no reaction. After the first treatment the numbness disappeared from the arm and hand. Only one dressing a day was required, while previously two or three dressings a day had been required because of the bloody discharge. After the sixth injection there was a lessening of the size of the mass with complete disappearance of the ulcerative area. The lesion was excised under local anesthesia about the middle of December, 1933. This was followed by a reaction at the time of the next blood injection. He has had two blood injections since (now April, 1934), and a reaction after each one. The wound is completely healed, and for the first time in thirty-five years this man has been without a dressing on his arm. The pathological diagnosis showed a chronic infectious granuloma with carcinomatous degeneration. No. 18 shows spectrum before reaction, and No. 25 after patient obtained reaction, showing complete disappearance of active "factor". This is a complete control.

Leukemias and sarcomas are the only other two conditions that we have found to show this active principle. They behave as to reactions and lack of reactions in the same way as do cases of cancer. I offer no explanation. *Plate No. 2, Spectrum No. 5* shows the spectrum of a leukemia with white count of 500,000 at the time the spectrum was taken. Injections of blood in three weeks (five) reduced the count to 350,000, but did not reduce the size of the spleen. Count at one time went down to 175,000. The patient was then placed in the Army Hospital and deep *X*-ray applied. The spleen was greatly reduced in size and the white count went down to 18,000. I have no further report at this time on this patient, other than that he is still living.

When the cancer patient gets a reaction from the treatment, his blood tends to give the same spectrum picture as that of a normal person. *Plate No. 2, Spectrum No. 19.*—This patient was a woman, forty-eight years of age, with a clinical diagnosis of carcinoma of the bladder which was treated by fulguration. *Spectrum No. 19* shows the blood at the time of the beginning of treatment. After seven treatments she had a reaction. The blood picture is shown in No. 30. At the beginning of the treatments there was pain and frequency of urination. There has been no pain since the third treatment, and the frequency has stopped. The patient now has treatments every two months.

Plate No. 2, Spectrum No. 26.—This was a patient with far advanced tuberculosis. This has been the only non-malignant blood that we have examined that has shown the spectrum extending beyond the line 16 on the top scale. This patient died from a pulmonary hemorrhage three days after this blood was taken. No postmortem was done.

In the use of the blood treated this way the serum itself is without effect. The whole blood or the red cells themselves appear to carry this "active factor", and only on hemolysis does this substance appear so that we can demonstrate it. This change goes hand in hand with the reaction shown by the patient. It appears to be present before cancer itself can be diagnosed clinically. The following observation is of interest. We found this "factor" in the blood of five patients who had no evidence of cancer. We treated three, but not the other two. Within two years these three did not develop clinical cancer that could be diagnosed. The other two developed cancer. One, a man, died from carcinoma of the lip, and the second, a woman, cancer of the uterus.

Plate No. 2, Spectrum No. 9.—This was a case of small, spindle cell sarcoma. This man was first seen in April, 1932, presenting a small walnut size mass on the lateral aspect of the right thigh. This was fixed to the skin and to the underlying tissues. It was removed under local anesthesia. The pathological diagnosis was small, spindle cell sarcoma.

The patient refused deep *X*-ray therapy, or the use of radium. Injections of irradiated blood were given at intervals of one week. This man was about seventy-two years old and wished to die, but he offered himself for experimentation in the use of this treatment. The result during the next three months was very encouraging. There was no recurrence and no metastasis. Having seen some lessening of the growths of carcinoma and increase in appetite following the oral administration of sheep bile, I gave it in this case. Within ten days there was a recurrence at the site of the old growth. Excision was done again, but was followed by recurrence which required seven exisions. Patient finally died in September, 1933. Death was due to loss of blood and lack of resistence from the open wound, which at this time was as large as both open hands. If this patient had been willing to allow an amputation of the leg, he might be living today, as there was no evidence of distant metastasis.

In this case the blood injections stopped pain. There was no evidence of metastasis, which is rare for a spindle cell sarcoma. Treatment prolonged this man's life and made it more comfortable.

DISCUSSION

1. The difference of hemoglobin content does not effect this reaction. But the fact that in cancer we get a gray solution when we filter the blood, and a red solution in the normal case, does bring up the point that there may be a different hemoglobin affinity.

2. The generalized carcinomatosis gives a spectrum similar to a normal blood. No satisfactory explanation of this can be given.

3. Cancer at a stage when diagnosis is not yet possible gives a spectrum change from the normal and control of this by use of irradiated blood injections suggests that we may have here something more than a test. It may mean prevention. The flexibility of response here points at a condition of "fastness" being present in the fully developed cancer. It may be that the tissue changes cannot be altered after cancer has developed. This is illustrated by No. 3 in Plate No. 2. Here, though the cancer was removed with no recurrence, the blood continued to show a positive finding.

4. The possibility is suggested that cancer is a deficiency condition.

5. Cancer from one human being has never been successfully transplanted to another. The microscopic picture of one carcinoma compared with that of another patient from the same organ may be morphologically similar. Yet we have to admit that the underlying physiology may be different. If that is true, then it is clear that "one pill of the same sort" cannot be used to "cure" both.

If we use the same medication for one and all types of cancer, we may not get the same response in all because we are dealing with different entities. Yet, with the underlying similarity of cancer in its growth and action on the human body, we have to accept cancer as a single species. If the difference in the chemical environment of cancer can be eliminated by the use of blood therapy which meets the individual peculiarity then we may entertain the possibility that one form of treatment may possibly answer the requirement to this point, the diagnosis and control of the precancerous and early lesions.

6. It is conceivable that the underlying chemical environment has to be altered before cancer can develop. Cancer as we know it today may be only a manifestation of the disease, the tumor mass itself corresponding to the rash of an erythematous disease.

CONCLUSIONS

First: We have accepted the present view that surgery, *X*-ray, and radium, are the only methods in use today that are of proved value in the attack on cancer. We are using *X*-ray in the form of a secondary irradiation.

Second: Our first fact is that by the use of autogenous blood the cancer patient does not get a reaction and the normal or non-cancer patient does. The use of these blood injections in malignant disease does produce benefit which warrants its use, but not by the untrained person.

Third: The demonstration of a spectroscopic difference between the irradiated "cancer" blood and normal blood is our second fact.

Fourth: The precipitate brings the hemoglobin down in the cancer blood and not in the normal blood.

Fifth: Not one patient of our 4,000 blood injections has produced a bad result. It is apparently harmless.

Sixth: Internal and external cancers can be treated in the same way by intravenous injections. Dressings of irradiated blood have been applied to external cancer, and about the same amount of benefit noticed as was produced by intravenous injections. The skin does not have to be protected as this blood appears to have effect only on the cancer.

Seventh: The demonstration of the presence of this "factor" before cancer is demonstrable makes the method of value at that stage, since the use of this method of treatment may act as a prophylactic.

Eighth: No better results are obtained by using larger amounts of blood. Seven cc. are enough. I use 20 cc. because that is a convenient amount to work with. One hundred cc. or 50 cc. produce no better results.

COMMENTS

Hugh Cabot, M.D., Rochester, Minnesota.—I have been interested in the work which Dr. Hyde has been doing for many years. His earlier results, which were largely based on clinical observation, are of course entirely indeterminate and not out of line with many extraordinary observations in regard to the disappearance of cancer under various methods of treatment not obviously based on scientific evidence. However, his more recent work, which appears to demonstrate a regular spectroscopic difference between the blood of patients having cancer and those apparently free from cancer, appears to me considerably more important. Furthermore, his observations of the reaction of patients to "treated" blood are interesting. His work appears to me to have got to the point where it is important. I think that it should be published and thereby made available to other investigators. After all, it is not single observations, but confirmed observations which constitute the sort of evidence of which we are in need. I am therefore glad that Doctor Hyde is putting forward his observations at this time in such a way that they can be studied by others.

THE PERIODIC HEALTH EXAMINATION

By LOUIS N. JENTGEN, M.D.,

COLUMBUS, OHIO

ONE year ago the Columbus Academy of Medicine appointed a committee on Periodic Health Examination. This committee began functioning immediately by accumulating data from all the states and possessions, in regard to the status of the periodic health examination. This data was very interesting and was to us a great impetus to go forward with this particular phase of preventive medicine. We found that many local medical societies and state organizations had pushed far into the possibilities and potentialities, while others had never given it a serious thought. This committee proceeded on the premise that preventive medicine is the cornerstone of modern practice—that the preservation of health should be a persistent thought in the minds of all aggressive and competent medical men.

Our work now started, three basic principles were adopted:

(1) To popularize the periodic health examination among the profession and educate them to the advantages of a periodic health examination practice.

(2) To popularize the examination among the laity.

(3) To instruct our society in the proper conduct of this examination and emphasize the desirability of having the examination made by the family physician.

Although the idea of the periodic health examination is very broad indeed we set up four very definite objectives:

(1) Cancer Prevention
(2) Tuberculosis Prevention
(3) Advancing Immunological Principles
(4) Cardio-vascular Disease Arrestment.

Special blanks were prepared, cards were printed to hang in the doctors' offices, small slips announcing the service were enclosed in the doctors' monthly statements.

A six-weeks radio program was broadcast at the start of our campaign, bringing to the attention of the laity pertinent points in public health, with special reference to the periodic health examination. Some of the subjects broadcast were as follows: (1) Vaccination (2) Diphtheria Immunization (3) Cancer (4) Health and Overweight (5) The Common Cold (6) Tuberculosis (7) Diabetes (8) High Blood Pressure (9) The Tonsil Question (10) Cardio-vascular Disease (11) Middle Ear Disease (12) The Sequela of Acute Febrile Disease (13) Appendicitis. These radio talks were very informal and spoken in a language easily understood by the laity. They were well received and gave our campaign some impetus. Several periodic health examination lectures were given the past season at the Columbus Academy of Medicine stressing cancer prevention, tuberculosis prevention, advancing the newer phases of immunology, and the arrestment of and care of cardio-vascular disease.

Now that I have described in a few words what

Read before the Section on Public Health and Preventive Medicine, Ohio State Medical Association, at the 88th Annual Meeting, Columbus, October 4-6, 1934.

the committee of the Columbus Academy of Medicine has done in regard to the periodic health examination I believe that it is opportune to discuss this examination in a frank way. The history of this examination is very interesting. Medical men have been thinking about it and only thinking for about seventy-five years. In 1922 the American Medical Association proceeded to appoint a committee to outline procedures and devise examination forms for making this type of examination. A booklet was printed outlining the ways and means. It met with some success, but this gradually fell off to a point of insignificance.

In 1933 at the Indianapolis meeting of the American Public Health Association it was pointed out statistically that in a given white group only ninety-one persons out of a thousand had a health check-up and of these only fourteen were above school age. In defense of the examinations, it appears that fourteen years of active life, five of which were full of chaos, has not been sufficient time to popularize such procedure. It is my personal opinion that there has been a definite lack of effective emphasis. Our committee has found a tremendous inertia on the part of our local profession to step up the progress of this examination. I think this is the answer to the laity's lack of enthusiastic interest.

The statement that the periodic health examination is unwholesome because it focuses the attention of the patient too closely on the functions of their bodies causing neuroticism, I believe is ungrounded. Of course the examination must be properly handled. We have neurotic people with us always; they were here before the periodic health examination. The doctor making the examination need not disclose minute physiological and anatomic details of minor or no importance; certainly he should be in position to know his neurotics and handle them accordingly. They have an inherent right to the Periodic Health Examination and it in turn has the same value to them as the non-neurotic. Helpful suggestions can be given them that may not only prevent some serious disease; but may also help their neuroses.

Many times on the floors of scientific meetings it has been held that the periodic health examination cannot and does not contribute to the discovery of insidious diseases that give no symptoms in their incipient stage. The Massachusetts Medical Society's committee regards the examination as a luxury. They advise to heed your body's complaints. This advice may be very good; but what of the diseases of which no early symptoms arise.

Surely with all the valuable statistics gathered by life insurance companies and their conservative methods of operation, the millions spent by them for medical examination would be futile if no information of importance would not have been gained from such examinations. We have all examined supposedly healthy people and found sugar or albumen in the urine. These things in the past have been regarded as having some significance and in my opinion have not lost it today. With the idea of heredity in the etiology of diabetes it would seem important and worth while to advise the diabetics' offspring of this possibility.

The newer thought in tuberculosis, especially with reference to the allergic status of the disease and re-infection would seem to me to be invaluable, worth many times the cost of a periodic health examination to the individual with a family history of tuberculosis. Early hypertension and cardiac enlargement run hand in hand. Recently the American Heart Association reports that 12 per cent of a group of a thousand men thirty-five years of age or older supposedly healthy and from sedentary occupations had an increased blood pressure. Surely timely advice would add years of usefulness to a group like this. How frequently today the doctor is called on the telephone to advise in matters of immunology and hygiene. This advice might well be given during the course of a well conducted periodic health examination with some financial rehabilitation to the medical man. The insidious cancer of the cervix or the breast might well be discovered at a periodic health examination.

Must we still ask the laity to discover them for us or bring to us well defined symptoms of advanced degenerative disease? Timely advice, warning and treatment surely can add years to the lives of these people unfortunate enough to acquire degenerative disease early.

In summing up these pertinent facts certainly the profession has a limited usefulness in this direction. In what better way may it be accomplished than through the medium of a well conducted periodic health examination? Due to the economic questions that arise in regard to an examination of this type, our committee prefers to classify the periodic health examination as a basic examination including a carefully taken history, complete physical examination with ordinary standard laboratory methods and procedures including urinalysis and blood examination. When indicated as result of the basic examination special procedures are to be suggested and the advisability of their use explained. As a general rule this minimizes the cost of the periodic health examination.

We believe the younger medical man will be more interested and enthusiastic in regard to this type of work. The honest and ethical application of the periodic health examination may be a means of early livelihood for him; it may divert many patients from the clinics, public health groups and lay laboratory organizations. It is the opinion of organized medicine that something must be done economically, so possibly this procedure may offer us some little ground on which to stand.

206 E. STATE STREET.

PUBLIC HEALTH -- SOCIAL WELFARE -- MEDICAL ECONOMICS *and* ORGANIZATION PROBLEMS

Increased Interest in Scientific Exhibit Urged

For the past few years, one of the most interesting and worth-while features of the Annual Meeting of the Ohio State Medical Association has been the Scientific Exhibit.

The Council of the State Association in authorizing exhibits and demonstrations of the scientific work being done by Ohio physicians has felt that it was enhancing the value of the Annual Meeting generally and providing members attending the meeting with an unusual opportunity to acquire valuable information regarding research being done here in our own state in medical problems.

Moreover, the Council has believed that the Scientific Exhibit would serve as an incentive to Ohio physicians to take a greater interest in scientific research.

Arrangements now are being made for the Scientific Exhibit to be held in conjunction with the 1935 Annual Meeting of the State Association in Cincinnati, Wednesday, Thursday and Friday, October 2, 3 and 4.

The Council Program Committee, composed of Dr. Parke G. Smith, Cincinnati, chairman, Dr. C. L. Cummer, Cleveland, and Dr. R. R. Hendershott, Tiffin, is, in addition to its other responsibilities, concentrating a great deal of effort on arrangements for the Scientific Exhibit.

Dr. Symmes Oliver, Cincinnati, has been appointed by the Program Committee as chairman of the Local Committee on Scientific Exhibit. Dr. Oliver has started activities which it is hoped will result in the scientific exhibits at Cincinnati being of distinct value and participated in by a greater number of physicians than ever before.

It is suggested that physicians consider the possibilities of preparing an exhibit for the Cincinnati meeting. Undoubtedly, many physicians through experience and study have evolved valuable methods of bedside treatment and perhaps have worked out laboratory findings of interest. The medical profession generally should know and have the benefits of their findings and work. There is no better way of informing the profession of them than through demonstrations or carefully prepared charts, photographs, etc.

The Scientific Exhibit offers those scheduled to present papers before the Cincinnati meeting an excellent opportunity to stimulate interest in their presentations and emphasize in a tangible way important points brought out in their papers. Essayists should consider the practicability of arranging exhibits based on their papers and entering them for the consideration of the Committee on Scientific Exhibit. Officers of the various scientific sections and others in charge of arranging section programs can be of much assistance in the preliminary work of arranging for the exhibits by suggesting to essayists that they take advantage of this opportunity.

Before being officially accepted all exhibits will be passed upon by the local Committee on Scientific Exhibit, the Program Committee and The Council of the State Association, insuring that the quality of all exhibits will be of a high level.

It is hoped that all section officers will cooperate on this matter and that a number of members will take advantage of this opportunity to participate in one of the most valuable features of the Annual Meeting. Due to the large number of details in connection with arranging for the Scientific Exhibit, it is suggested that those desiring to enter exhibits get in touch as soon as possible with Dr. Oliver, 628 Elm Street, Cincinnati.

—OSMJ—

Individual Activity An Adjunct of Organized Effort

Repeatedly *The Journal* has emphasized this point: The most effective way for the medical profession to keep the public enlightened regarding the aims and motives of the medical profession and win public sentiment in support of the views of the medical profession on social, economic and legislative questions affecting medical practice is through the individual physician in his daily contacts with the public.

As problems multiply, this statement becomes more logical and pertinent.

If the medical profession is to be successful in the important issues now confronting it, there must be a rejuvenation of active personal interest in public affairs among the profession generally.

On this point, we submit the following communication disseminated recently by the Committee on Legislative Activities of the American Medical Association, which is a challenge to the interest and initiative of every physician:

"The action of the House of Delegates of the American Medical Association in reaffirming its opposition to proposed compulsory sickness insurance plans has had a far reaching effect.

"Delegates, and Officers of the State Associations have conveyed the spirit of the deliberations and action of the House to their respective organizations in a manner which has been especially gratifying.

"Many State and County Medical Societies have taken action opposing sickness insurance and have made their action known to the President, Bureau Heads, and Members of Congress.

"It is reported from Washington that the Medical Profession has never before made its united position known to Legislators in such an impressive manner.

"The indisputable evidence presented, indicating that the best interests of the public would not be served by proposed sickness insurance plans, must command the respect of those who will be responsible if any legislation is enacted.

"Much has been accomplished since the House of Delegates in 1934 authorized the Board of Trustees to proceed with a program of direct approach to the lay-public in discussion of sickness insurance.

"Large and influential groups have been contacted and much more is known of the extent of public interest and the attitude toward sickness insurance.

"The Committee wishes to point out, however, that there remains one phase of this program which must be more actively carried on.

"*The interest and activity of the individual physician must be aroused to the degree that he will inform himself concerning sickness insurance, and present such information to the lay-public which he contacts. In this way he will aid greatly in crystallizing public opinion against harmful legislation.*

"Reports to the Committee indicate that the individual citizen of influence, who has been misled by public statements that needed medical care is not available to those financially less fortunate, has, from radio talks, magazine articles, and other propaganda, come to believe that sickness insurance is desirable. Such a man can best be contacted through his personal friend, his physician.

"The best interests of the patient and the best interests of the physician are common, and it is not inconsistent with the ethical teaching of Medicine for the physician to advise with him concerning sickness insurance. No special technique is needed in making individual lay-contacts.

"The physician is generally not without some ingenuity in matters of local interest. If he is opposed to some local project he does not hesitate to approach others in order to impress upon them the undesirable character of the proposal or to enlist their assistance in defeating it. Certainly there could be nothing of more vital importance than the threatened measures.

"Effort must now be put forth to arouse the individual physician to interest in his own position and to his responsibility to others.

"Communication to Secretaries of County Societies alone frequently put upon those overworked local Officers the whole burden of conducting a campaign in which the Officers of that Society should have the assistance of District or State Officers or others.

"Literature and information on Sickness Insurance Legislation, having been mailed only to Society Secretaries, have frequently not come to the attention of many of the members. In many states every member has been directly addressed many times. Most medical societies do not meet regularly during the summer months and immediate action is necessary.

"The American Medical Association will furnish needed literature on request."

Hospital Building Program at This Time Inadvisable

At the recent meeting in Columbus of the Ohio Hospital Association, the financial troubles of hospitals generally were aired.

Robert Jolly of Houston, Texas, president of the American Hospital Association, told his Ohio colleagues that competition by government-owned and government-operated hospitals had caused some of the economic difficulties confronting private hospitals.

The Rt. Rev. M. F. Griffin, Cleveland, an official of both the Ohio and national hospital groups, severely criticized the Federal Emergency Relief Administration for not providing financial aid for private hospitals in the care of those on the relief rolls.

While many of the thoughtful leaders in the hospital field are giving serious attention to means of solving the problems of hospitals now in existence and struggling to exist, a small group of individuals are carrying on a campaign designed to convince the Federal Government that public works funds should be allocated to the building of new hospitals in some 500 or 600 rural communities.

In the light of accurate data and the far from optimistic situation confronting all hospitals, it would seem that this movement should not at this time receive serious consideration.

Figures recently compiled by the Council on Medical Education and Hospitals of the American Medical Association showed that the number of idle hospital beds in 1934 reached a record total of some 218,000 and that the number of hospitals had decreased by 103. It was reported that 2,003 rural hospitals in the United States during 1934 had but 50.2 per cent of their beds occupied and that 2,031 urban hospitals had a bed occupancy of but 62.4 per cent.

Commenting on this situation, the editor of *The Journal of the American Medical Association* points out:

"While an occasional area might at this time actually require a hospital and be able to support one, the percentage of unoccupancy would indicate the hazard as either a commercial, scientific or philanthropic venture of attempting to establish new hospitals in a period of economic stringency such as now exists."

If the Federal Government should undertake to finance the building of several hundred new hospitals, it must at the same time face the probability of providing funds for operating expenses. In other words, such institutions must necessarily be government hospitals. This would in effect be adding greater competition for hospitals already in the field, making more serious the very problem emphasized by Mr. Jolly in his address in Columbus.

The movement carries a hidden danger to the medical profession. If erected, these 500 or 600 new hospitals must be adequately staffed. It is doubtful if many rural communities would have sufficient medical personnel for this purpose. A natural step, therefore, would be to secure such personnel through subsidies or otherwise and expand the activities of government in the field of medical practice.

Instead of extending its activities in the hospital field, the Federal Government should reconsider the allocation of funds for the hospitalization of relief patients which in itself would be a definite step in relieving part of the burden the existing hospitals are shouldering.

—OSMJ—

Heredity, Temperament and Longevity

The longer a physician practices the more he is convinced of the vital part which heredity plays in the life of the average human being.

Medical science has made great advances and has accomplished wonders. Yet, there are some things which even modern scientific medicine has been unable to explain or conquer, mostly because of the peculiar biological characteristics handed down from generation to generation and which defy all efforts of science to overcome.

In a recent issue of *The Forum*, Raymond Pearl, of Johns Hopkins University, summarizes his studies of longevity in relation to inherited characteristics. He concludes that heredity and temperament are the two most vital factors which must be considered in why some persons live to a ripe old age and others die young. His observations are brief but to the point and merit careful thought. To quote:

"No sibylline oracle or scientific formula can predict how long you will or ought to live; all that science can do is prepare tables showing you how long human beings actually *do* live, then let you estimate your own chances. If, for example, you aspire to round out a Biblical 'threescore years and ten' on earth, the tables indicate that you have slightly more than one chance in three of doing so. Life-insurance statistics reveal that out of each 100 persons born in the United States, over a third are alive at 72. A decade later, about 12 of the original 100 are still living. Thereafter, the odds against further longevity rise more rapidly. Only one or two of 100 starters in life's race ever pass the 92nd milepost.

"As for spanning a full century—well, a genuine centenarian, you may console yourself, is exceedingly rare. No person has ever advanced indisputable proof of having lived more than about 110 years, and such famous cases as that of 'Old Parr' (reputed to have died at the age of 152) are deserving of no credence whatsoever.

"For a number of years I have kept exhaustive records of persons who have lived to be 95 or older, and from an analysis of these records—some 2,000 carefully authenticated cases—it has been possible to derive a composite picture of the biologic, physical, and temperamental equipment possessed by persons who might be called 'practicing Methuselahs.'

"The first and by far the most important requisite of longevity, as these actual case histories show, is having ancestors who were long-lived. In other words, you inherit the biological characteristic of living a long time, just as you inherit blue eyes or red hair. If your forbears died young, you have a relatively poor chance of breaking any long-distance records in the life marathon but, if your parents and grandparents lived to a ripe old age, you probably will in some degree inherit this same biological trait.

"Let us take an example from our records—Case P191. Mrs. P191 is a hale and hearty nonagenarian. Her father died at 78 years of age, and her mother at 91. Her paternal grandfather reluctantly left this vale of tears after a sojourn of 99 years and 6 months; his wife, P191's grandmother, died at the respectable, if not particularly extraordinary, age of 78. But the grandmother on the mother's side did better. She stayed around for 94 years. Her husband unfortunately died of typhoid infection at 35 years of age. But anyone whose parents and grandparents together lived over 475 years has a sound background of family longevity.

"Actuarial studies we have made show that the contribution of heredity to longevity can be precisely measured. As an example, consider two groups of baby boys. All the fathers of all the boys in one group died before they were 50 years of age; the fathers of the other group all lived to be over 80. The average duration of life of the babies in the second group was 22 per cent greater than in the first group—more than 10 years per person, on the average, of longer living.

"Next to heredity in insuring long life, seems to be the matter of temperament. Are you naturally tranquil-hearted, and does your temper ride an even saddle? Let us hope so, for the calm and contented type seems to have a very important advantage in the old-age sweepstakes over the person who is fretful, irritable, and inclined to worry.

"The evidence also tends to show that the person who avoids too-strenuous exercise after 40 and does not engage in heavy muscular labor has a much better chance of long life than the misguided chap who overtaxes his middleaged boilers with a freshman head of steam.

"One of the commonest myths about longevity is the notion that dietary coddling and abstinence from alcohol and tobacco will guarantee a full harvest of years. In the records there appears to be little to support this admirable but deluded point of view. Some of the persons on the list of nonagenarians have been lifelong teetotalers and abstemious eaters; others have habitually tamped home vast cargoes of food and quaffed Olympian draughts of malt and vinous liquors whenever thirst so dictated. Many of them smoked cigars, pipes, and cigarettes; others abhorred tobacco in any form. Some lived amid toxic urban fumes; others inhaled nothing but pure country air. None of these things appeared to affect longevity either favorably or unfavorably.

"Obviously abuse can wreck a sturdy frame, but it is also true that no amount of dietary solicitude and no heroic devotion to a 'daily dozen' will carry an individual into advanced old age if he has a constitution biologically inadequate for the journey. To put it another way, it makes less difference what you *do* than what you biologically *are*.

"A thing that is noticeable in the old-age records generally is that few persons who live past 90 have ever had a surgical operation or, if they have, the surgery has been of a minor character. There is nothing mysterious about this fact; it merely means that people who live to be 90 or more are the kind of people who constitutionally are not susceptible to surgical diseases. Major surgery, in a broad sense, is the branch of the science of medicine which devotes itself primarily to the correction of innate, constitutional biological defects of the individual. Nonagenarians, by and large, have no such defects.

"This leads to another odd paradox. No small number of the persons in our collection of cases have 'enjoyed poor health,' as the phrase goes, throughout the greater part of their long lives. The reports say that they have 'always been sickly,' or 'frail,' or 'semi-invalid.' This is really not surprising. It has long been known, from a variety of evidence, that morbidity and mortality do not connote the same things biologically. A person may have a great deal of sickness, continued intermittently over many years, and yet live to a ripe old age.

—OSMJ—

Credits and Collections

Summing up some of the activities of the Credit Bureau of the Toledo Academy of Medicine, the "Education Echoes" department of the *Toledo Academy Bulletin* recently pointed out some of the difficulties of the medical profession with regard to economic and business affairs.

One point raised, involving a simple yet fundamental phase of any business transaction, merits careful consideration from every physician who is interested in keeping the economic side of medical practice apace with the scientific.

"Our Academy Bureau has discovered one very flagrant flaw in the business methods employed by most of us doctors", the "Education Echoer" writes.

"That is the omission of a definite statement as to the cost of certain services before they are rendered. How many of us purchase a suit of clothes without asking the price? Or an automobile? Or what not? Think of your amazement if you did buy an overcoat that appealed very much to you in tailoring and material and you were billed a price far in excess of what you had in mind should be collected. Dispute and dissatisfaction between yourself and the merchant would immediately arise—even though the overcoat be worth all that was asked. The same thought applies to the layman and our services. More often than not, the patients have not the least idea of what certain services are worth. In the majority of cases definite understandings beforehand lend themselves to definite and more prompt settlements later".

The idea presented has a place in the practice of every physician. Naturally, definite understandings regarding fees cannot be had between physician and patient in all instances. Occasionally the physician has no idea when he takes over the complicated case just how much service will be required to treat the patient. However, in the great majority of cases, the physician can furnish some kind of an estimate as to the scope and extent of the service and the approximate customary fee for such services. No hard and fast rule can be applied in every case but the more frequently the physician makes it a point to have a frank understanding with his patients regarding their end of the contract, the better chance he has of maintaining a satisfied clientele, at least insofar as financial matters go.

—OSMJ—

Mr. Charles Nelson—Executive Secretary

Mr. Nelson was born in Marion, Ohio. He attended Ohio State University and graduated in 1921. He entered journalism and was successively connected with the *Marion Star*, Marion, and *The Columbus Citizen*.

As may be noted in the minutes of the last Council meeting, Mr. Charles S. Nelson was elected Executive Secretary of the Ohio State Medical Association.

In 1928 he was elected as Assistant to the Executive Secretary of the Ohio State Medical Association and continued in that position until the resignation of Mr. Don K. Martin in March, 1935.

Under Mr. Martin's direction he acquired a thorough knowledge of the aims and policies of the State Association and has given unstinted service in promoting the interests of the organized medical profession. He has been the contact man with the various State Departments in behalf of the Association and the membership in general. His industry, ability and tact have played no small part in maintaining the efficiency of the central office administration.

He was recommended unanimously by the committee on the extension of medical activities for his present advancement and it is planned that he will have a considerable share in that extension, and by attendance at District and other meetings he will, by closer personal contact with the officers and members of the constituent county organizations, gain a more thorough understanding of the many local problems, and so bring about a more complete cooperation and harmonious action of all the activities of organized medicine in our state. **J. H. J. Upham, M.D., Chairman Special Survey Committee on Extension of Activities and Headquarters Personnel.**

EXTENSION OF SCIENTIFIC ACTIVITIES OF STATE ASSOCIATION, SELECTION OF STATE OFFICE EMPLOYES, POOR RELIEF PROBLEMS, ACTED ON BY COUNCIL AT APRIL MEETING

MINUTES

The Council of the Ohio State Medical Association met in the headquarters office, 1005 Hartman Theatre Building, Columbus, Sunday, April 14, 1935, in special session.

Those present were: President, Dr. Caldwell; President-elect, Dr. Hendershott; Past President, Dr. Cummer; Councilors, Drs. Smith, Huston, Klotz, Hein, Jenkins, Davidson, Kirkland, Seiler and Goodman; Dr. Upham, chairman, Dr. Platter, member, Policy Committee, and members of the Special Committee on Extension of Activities; and Acting Executive Secretary Nelson.

The minutes of the Council meeting held on March 10, 1935 (pages 279 to 282, inclusive, of the April, 1935, issue of *The Journal*) were read, and on *motion* by Dr. Jenkins, seconded by Dr. Kirkland and *carried*, were *approved*.

Report of Special Committee on Extension of Activities and Headquarters Office Personnel (Executive Session)

Dr. Caldwell announced that the Council would go into executive session for the purpose of considering the report of the Special Committee on Extension of Activities and Headquarters Office Personnel appointed by him upon the authorization of the Council at its last meeting, and consisting of Dr. Upham, chairman, Dr. Hendershott, Dr. Cummer, Dr. Freiberg and Dr. Platter. By invitation, Dr. Upham and Dr. Platter were present at the executive session.

The report of the special committee was presented by Dr. Upham and considered section by section by the Council. The first matter acted upon was that of the selection of the permanent personnel for the state headquarters office.

After discussion and consideration, the Council, upon *motion* by Dr. Huston, seconded by Dr. Jenkins and *carried*, appointed Mr. Nelson executive secretary, succeeding Don K. Martin, whose resignation became effective last March 15. Upon *motion* by Dr. Huston, seconded by Dr. Klotz and *carried*, the salary of the executive secretary was fixed at $5,000 per annum effective April 15.

Dr. Upham reported that the special committee had given careful study to the qualifications of a large number of applicants for the position of assistant executive secretary; had held personal interviews with the most likely candidates, and that it was the recommendation of the committee that George H. Saville, Cleveland, be employed as assistant executive secretary. Upon *motion* by Dr. Seiler, seconded by Dr. Hein and *carried*, Mr. Saville was appointed at an annual salary of $3,600.

Upon recommendation of the special committee and on *motion* by Dr. Klotz, seconded by Dr. Davidson and *carried*, Miss Alice B. Haney was reappointed membership secretary and bookkeeper at an annual salary of $2,500.

It was *moved* by Dr. Huston, seconded by Dr. Seiler and *carried*, that Miss Jean Helfrich be reappointed as stenographer at an annual salary of $1,800.

Dr. Upham reported the special committee had made a detailed study of ways of enhancing the service of the State Association to the membership and extending its activities, and had drafted a number of definite recommendations for consideration of the Council.

The first recommendation was that the State Association actively cooperate with the individual Councilors and the various county societies in the respective Councilor Districts in the matter of arranging for district scientific meetings at least once every year. It was suggested that such meetings be held in strategic points in each district under the direction of the District Councilor, who should arrange and be responsible for the details of the meeting.

Dr. Upham stated the special committee felt that some such plan as suggested would bring the Councilors in closer contact with the membership in his district, stimulate interest in the district, bring out new workers in organized medicine, establish a closer contact between the county medical society officers and members of the central office, and in general demonstrate the manner in which the State Association can directly contribute to the medical and educational interests of the membership.

It was the opinion of the special committee that the executive secretary should attend such meetings and thus have an opportunity of meeting personally many of the county society officers and members, and carry a brief message from the State Association.

The special committee suggested that to assist the component county medical societies in arranging for such district meetings and in obtaining one or more outstanding speakers for the scientific program, a portion of the State Association funds might be allocated as subsidies to the

various Councilor Districts for this definite purpose.

On *motion* by Dr. Smith, seconded by Dr. Seiler and *carried*, this recommendation of the special committee was *approved*, including authorization for the expenditure of State Association funds when requested by the respective districts for this purpose, not to exceed $200 in any one district per annum.

The report of the special committee emphasized the need for more frequent meetings of the Council, and it was recommended that the Council meet in regular session at least once every two months.

On *motion* by Dr. Smith, seconded by Dr. Huston and *carried*, this recommendation was *adopted*.

The recommendation of the committee that consideration be given to securing facilities for reporting discussions on papers at the scientific sessions of the Annual Meeting, in order to stimulate better discussions and provide more interesting material for *The Journal*, was, on *motion* by Dr. Cummer, seconded by Dr. Huston and *carried*, referred to the Council Program Committee, with instructions to secure such facilities if advisable and feasible for some of the General Sessions of the forthcoming 1935 Annual Meeting in Cincinnati.

Dr. Upham reported that the special committee had given serious consideration to the matter of improving *The Journal* and making it of greater interest and value to the members, possibly through rearrangement of make-up, greater emphasis on the scientific section, the securing of a greater number of scientific papers, and publication of scientific editorials, abstracts of special interest, book reviews, etc.

Following prolonged discussion of this recommendation and on *motion* by Dr. Smith, seconded by Dr. Klotz and *carried*, the Council authorized the continuance of the Special Committee on Extension of Activities and instructed it to collaborate and cooperate with the Publication Committee in rearranging *The Journal* to conform with the suggestions enumerated in the committee's report.

The committee presented for consideration, the possibility of the organization of a speakers' bureau at the State Headquarters Office, which would maintain a list of speakers and topics from which county societies might secure essayists for county society meetings. The report suggested that should such a bureau be organized, the State Association might contribute toward the traveling expenses of such speakers when their visit is authorized by the bureau. On *motion* by Dr. Klotz, seconded by Dr. Seiler and *carried*, action on the organization of a speakers' bureau was deferred until a later meeting of the Council.

The question of employing legal counsel for the State Association, on *motion* by Dr. Cummer, seconded by Dr. Goodman and *carried*, was referred to the Committee on Auditing and Appropriations for study.

The Council was apprised of the fact that the changes and recommendations acted upon favorably by the Council would necessitate some reallocation in the present State Association budget, but that the total budget required, including an estimated expenditure of $2,000 for district meetings, is considerably less than that formulated by the Council for the calendar year 1935.

At this point the executive session ended and the Council took up other matters docketed for its consideration.

1935 Annual Meeting

Dr. Smith, chairman of the Council Committee on Arrangements and the Council Program Committee, reported on progress to date and on various matters considered by the Program Committee at its meeting on the morning of this day. He stated that the Program Committee was negotiating to secure without cost, except for express charges and possible breakage, view boxes for the scientific exhibits from the Radiological Society of North America.

Dr. Smith stated that the program for the Cincinnati meeting is approximately 75 per cent completed and that efforts to secure a speaker for one of the General Sessions and for the annual banquet are progressing.

Dr. Smith presented a request from the Cincinnati Chamber of Commerce for permission to send circular letters to members of the Ohio State Medical Association to promote the Cincinnati meeting. On *motion* by Dr. Davidson, seconded by Dr. Klotz and *carried*, such permission was granted and the State Headquarters Office instructed to handle the addressing of envelopes for such circulars.

The question of a speaker for the annual banquet was considered, and on *motion* by Dr. Cummer, seconded by Dr. Goodman and *carried*, the Program Committee was instructed to spend not to exceed $150 from Annual Meeting funds to assist in defraying expenses of a banquet speaker.

On *motion* by Dr. Davidson, seconded by Dr. Goodman and *carried*, the Council approved the acceptance of commercial exhibits at the Annual Meeting by cigarette companies which are regular advertisers in *The Journal*.

Problems of and Report on Medical Poor Relief

The attention of the Council was called to serious problems which have arisen in various parts of the state in connection with the state-wide medical poor relief program. It was pointed out that physicians in several counties had notified state relief officials they would refuse to cooperate with local relief officials unless immediate changes were made in the present medical pro-

gram and provision made for more adequate compensation to physicians.

Dr. Upham, chairman of the Policy Committee, presented a detailed report on a conference his committee had held on the previous day with Mr. C. C. Stillman, FERA Administrator in Ohio, at which these serious problems had been discussed. Dr. Upham stated that this was the most encouraging conference which the State Association had held with the state relief officials during the past year and a half. He said that Mr. Stillman expressed sympathy with the difficulties confronting the medical profession and intimated that he desired to work out, in cooperation with the State Medical Association, a new medical relief program which would insure adequate care for the indigent and at the same time more equitable compensation for physicians.

Dr. Upham declared that the Policy Committee intended to take immediate steps to secure information from various parts of the state and to submit as soon as possible to Mr. Stillman, recommendations for improvement in the present medical set-up. He urged the members of Council to submit data on situations in the counties in their districts, accompanied by constructive suggestions for modification of the state-wide medical relief program. Members of Council expressed their views on this question, the consensus of the majority being that provision must be made for a more flexible budget for medical care under the FERA and elimination, if possible, of the arbitrary maximum of $1.00 per family per month. Members expressed themselves as pleased with the attitude of the present state relief officials and were of the opinion that the medical profession of the state must take this opportunity offered to them to assist in drafting a more equitable medical set-up. The Councilors in those districts where physicians have threatened to withdraw from the poor relief program were instructed by the Council to contact the proper officers of the county medical societies involved, and to urge that drastic action be postponed pending further negotiations with Mr. Stillman.

On *motion* by Dr. Hein, seconded by Dr. Davidson and *carried*, the Policy Committee was instructed to communicate at once with the proper officers or committeemen of each county medical society to obtain from them detailed information on poor relief difficulties in their county and request comments and suggestions from them on the question of modifying the present medical relief program.

For the information of the Council, Dr. Huston and Dr. Davidson described briefly the activities, respectively, of the Montgomery County Medical Society and the Summit County Medical Society in handling medical service under the FERA.

Legislative Developments

The Council was presented with information on developments in the Ohio General Assembly and the status of various proposals in which the medical profession is vitally concerned. Members of Council reported on contacts with members of the Legislature and were urged by Dr. Upham, chairman of the Policy Committee, to continue to stimulate activity among the members of the county societies in their respective districts.

Survey of State Government

Dr. Hein, chairman of the Special Committee on Workmen's Compensation, reported on cooperation of that committee with the Sub-Committee on Workmen's Compensation of the Sherrill State Government Investigating Committee. He said that considerable data which have been assembled by the State Association over a period of years had been submitted to that committee at its request, and that some of the imporant recommendations of the State Association for improvements in administration of the Workmen's Compensation Law probably would be carried in the final report of the Sherrill Committee.

Dr. Hein also discussed briefly the present workmen's compensation situation, stating that there had been a marked improvement in the financial status of the workmen's compensation fund. However, he pointed out that the entire workmen's compensation system is jeopardized by several destructive bills now pending in the Legislature and expressed the opinion that the medical profession should do what it can to bring about their defeat.

It was pointed out that the State Association Headquarters Office also had been in conference wih sub-committees of the Sherrill Investigating Committee studying the activities of the State Department of Health and the administrative procedure of various state licensing boards, such as the State Medical Board, State Dental Board, State Pharmacy Board, etc.

Report of Judicial Committee

Dr. Cummer, chairman of the Council Judicial Committee, reported on the revised Constitution and By-Laws submitted by the Academy of Medicine of Lima and Allen County. He pointed out the Judicial Committee felt that it would be inadvisable for the inclusion in the By-Laws submitted of the provision for disciplinary action against physicians participating in malpractice suits, because of legal questions which might arise. Dr. Cummer also requested that the attention of the Lima Academy should be called to the fact that under the provisions of Chapter I, Section 8, of the By-Laws no distinction is made between expulsion and suspension of a member. After some discussion, on *motion* by Dr. Cummer, seconded by Dr. Seiler and *carried*, the Council *approved* the Constitution and By-Laws of the Academy of Medicine of Lima and Allen County with the exception of Section 5 of Chapter II of the By-Laws which was ordered deleted, and

instructed the executive secretary to communicate to the Academy the opinion of the Judicial Committee on the matter of suspension and expulsion.

New Alternate Delegate to A. M. A.

A communication was read from Dr. Olin West, Secretary and General Manager of the American Medical Association, pointing out the ineligibility of Dr. A. C. Messenger, Xenia, to serve as alternate delegate for Dr. Ben R. McClellan to the American Medical Association's annual session in Atlantic City, June 10 to 14, because of the expiration of his fellowship in the A. M. A. in May, 1934.

On *motion* by Dr. Huston, seconded by Dr. Seiler and *carried*, Dr. D. W. Hogue of Springfield was appointed by the Council to succeed Dr. Messenger as alternate delegate for Dr. McClellan.

A. M. A. Conference on Medical Economics

A request from the Bureau of Medical Economics of the American Medical Association for an official representative from the Ohio State Medical Association at a meeting to be held in Chicago, April 27, for the purpose of discussing medical service plans now being conducted in various parts of the country, was presented to the Council for its consideration. It was the sentiment of the Council that a representative from this Association should attend the meeting. On *motion* by Dr. Huston, seconded by Dr. Seiler and *carried*, the Council authorized Dr. L. L. Bigelow, chairman of the Committee on Medical Economics, to represent the State Association at the Chicago meeting, and in case of his inability to attend, that the President name an official representative.

Miscellaneous

A communication from the Clark County Medical Society requesting the State Association to publish for distribution an article entitled "Cured by Clinics", published in the March issue of the Readers' Digest, was, on *motion* by Dr. Smith, seconded by Dr. Klotz and *carried*, referred to the Committee on Public Policy.

Recent correspondence and reports on conferences concerning difficulties between a number of Mansfield physicians and the Mansfield Telephone Company were presented. It was pointed out that apparently the Mansfield Telephone Company is conforming to regulations of the State Utilities Commission in the matter of charging business rates for telephone service to physicians whose office is in their residence and who desire professional listing and on *motion* by Dr. Huston, seconded by Dr. Smith and *carried*, the Council expressed itself as believing the question is not within the jurisdicton of the State Association and should be worked out locally by physicians and the Mansfield Telephone Company.

Dr. Jenkins submitted for the information of the Council a report on difficulties which have arisen in Cleveland over questionable publicity submitted to the newspapers by a number of Cleveland hospitals. He called attention to a letter sent to such hospitals by the President of the Cleveland Academy of Medicine citing the action of the House of Delegates of the American Medical Association at its Cleveland meeting in declaring unethical certain kinds of publicity by clinics, hospitals, sanatoriums and other medical institutions.

Discussion was held on developments in Congress on the social security measure and on the action of the California State Medical Association in approving the principle of compulsory health insurance.

A report on membership statistics showed that 4,911 members to date had their 1935 dues certified to the State Headquarters Office, as compared with 4,788 on the same date last year and with the total for last year of 5,361.

There being no further business, the Council adjourned to meet at the call of the President.

Signed: S. J. GOODMAN, M.D.,
Secretary of Council.

—OSMJ—

American Public Health Meeting

The 64th Annual Meeting of the American Public Health Association will be held in Milwaukee, Wisconsin, October 7-10, 1935. Several related organizations have announced that they will meet simultaneously with the American Public Health Association at Milwaukee. They are: American Association of School Physicians, International Association of Dairy and Milk Inspectors, Conference of State Sanitary Engineers, International Society of Medical Officers of Health, Association of Dairy, Food and Drug Officials, Conference of Wisconsin Health Officers, Conference of State Laboratory Directors, Association of Women in Public Health.

—OSMJ—

Dr. Kline Wins Eisenman Award

Dr. Benjamin S. Kline, chief of the laboratory at Mount Sinai Hospital and assistant professor of pathology at Western Reserve University, has been awarded the Charles Eisenman Award of the Jewish Welfare Federation.

The presentation was in recognition of Dr. Kline's contribution to medical knowledge in research on pneumonia and his discovery of a precipitation test for diagnosis and exclusion of syphilis. Dr. Kline said he would turn the $1,000 prize accompanying the award to Mount Sinai Hospital for further medical research.

PERTINENT REGULATIONS ON PRESCRIBING AND ADMINISTERING NARCOTICS SUMMARIZED AS TIME FOR RENEWING PERMITS NEARS

EVERY physician wishing to prescribe or dispense narcotics must register with the Collector of Internal Revenue of his district and pay the Federal tax of $1.00 on or before July 1 annually.

Renewal of his narcotic permit should serve as a reminder to every physician of the severe penalties for violation of the provisions of the Harrison Narcotic Act.

It should cause each physician to make certain that he is complying with the regulations issued in accordance with its provisions and the intent of such regulations.

Confusion still exists in the minds of some physicians as to the meaning of some of the narcotic regulations, the essence of which is *good faith on the part of the physician and the bona fides of his treatment in a given case.*

For that reason, the following detailed explanation of the provisions and regulations of the Harrison Narcotic Act is presented for the information of the membership generally, abstracted from an article written by Dr. William C. Woodward, director of the Bureau of Legal Medicine and Legislation of the American Medical Association, and published in *The Journal of the American Medical Association.*

LICENSE COSTS $1.00 A YEAR

Registration.—On every practitioner who uses narcotic drugs professionally, the federal government imposes a tax of $1 a year. A practitioner must pay this tax and be registered before he can obtain narcotic drugs for professional use, or administer, dispense or prescribe such drugs, except that he may administer or prescribe, but not dispense, certain more or less attenuated narcotic preparations, commonly referred to as the "exempt preparations."

A practitioner desiring to register must make application on a form furnished by the collector of internal revenue. When he files his application, he must deposit with the collector the required tax, $1, which is payable for any year or any part of a year. Such an application must be filed with the collector of internal revenue in each district in which the practitioner intends to maintain an office. If he intends to maintain more than one office even in one collection district, he must register each office separately. A practitioner, however, who maintains an office duly registered with the collector of internal revenue, where his stock of narcotic drugs and his narcotic records are kept, may administer, dispense and prescribe such drugs in other collection districts in which he may engage in practice, without incurring additional tax liability, provided he opens no office or offices in such other collection districts.

Information as to the identity and location of the local collector of internal revenue can be obtained from the postmaster or from any bank or any practitioner already registered. The local collector of internal revenue will supply information as to the boundaries of collection districts.

On the filing of a practitioner's initial application for registration, the collector of internal revenue refers it to the narcotic agent in charge in the district, for his information, and investigation if necessary. The collector is guided by the recommendation of the narcotic agent in determining whether an applicant shall or shall not be registered. A practitioner who is authorized by the laws of the jurisdiction in which he practices to use narcotic drugs professionally is entitled, however, to registration as a matter of right, but he must furnish the collector with adequate evidence of that right. If there is any question as to the authority of an applicant with respect to this matter, the narcotic agent and the collector of internal revenue are guided by the construction placed on the local statutes by the officers of the jurisdiction in which the applicant is practicing or is to practice. If a practitioner's application and credentials satisfy the narcotic agent and the collector of internal revenue that he is entitled to registration, he may register. A practitioner's initial registration can be effected at any time, but thereafter he must register on or before the first day of July of each year, preferably in June, paying the same tax, $1, every year. He retains his original registration number from year to year.

REGISTRATION NUMBER AND TRANSFERS

When a practitioner first registers, he is assigned a registration number and given a "special tax stamp." At this time he should obtain a supply of official order forms, which are necessary to enable him to purchase narcotic drugs for his professional use. The special tax stamp must be kept conspicuously posted in the office named on it. The significance and use of the registration number and the order forms will be described later.

If a registered practitioner transfers his office from one location to another, he must report that fact to the collector of internal revenue of the district in which the old office was located and have the transfer entered on the face of his special tax stamp. Such instructions as may be needed for the completion of the transfer of

registration should be obtained from the collector when the transfer is reported to him.

If a practitioner fails to register and to pay the required tax within the time fixed by law, a penalty of 25 per cent is added when the tax is paid. This may be remitted, however, by the Commissioner of Narcotics, if adequate cause is shown for the failure. A practitioner who has registered tardily, and who has used narcotic drugs professionally during the interval within which his registration has lapsed, is liable to be fined not more than $2,000 or to be imprisoned for not more than five years, or both. A practitioner whose record is good and whose tardiness in registration is looked on as probably an oversight may be given an opportunity to explain his default and to tender an offer of money by way of compromise. If his explanation and tender are acceptable to the Commissioner of Narcotics, he may be able thus to escape criminal prosecution and all that it implies.

What has been said thus far with respect to registration has had reference to the use of narcotic drugs generally. If a practitioner desires to *dispense* any of the so-called exempt narcotic preparations, as distinguished from administering and prescribing them, he must register in a special class.

WHERE, HOW TO PROCURE NARCOTICS

Procuring Narcotic Drugs for Professional Use.—A practitioner who desires narcotic drugs for professional use, other than exempt narcotic preparations, must obtain them from a registered wholesale dealer, except that he may obtain aqueous or oleaginous solutions in which the narcotic content does not exceed 20 per cent of the complete solution, in quantities not exceeding one ounce at any one time, from a registered retail dealer, to be used in legitimate office practice. No narcotic drug or preparation, other than those just named and the exempt narcotic preparations, can be lawfully purchased for office use from a retail dealer. Prescriptions for nonexempt narcotic drugs for the prescriber's professional use cannot lawfully be issued or filled. The writing of prescriptions for fictitious patients, to obtain narcotic drugs for general professional purposes, to avoid the use of official order forms and to avoid making purchases from registered wholesale dealers, is not permitted; narcotic drugs obtained on prescriptions are for the exclusive use of the patients named in such prescriptions. All purchases for general professional use must be written on official order forms.

Official order forms may be purchased at a nominal cost from the collector of internal revenue with whom the practitioner is registered. Requisition blanks for the purchase of order forms can be obtained from the collector. Each order form bears at the time of delivery the name, address and registration number of the registrant for whose use it is issued and designates the class of registrants to which he belongs. In purchasing narcotic drugs, order forms must be executed in duplicate. The original is to be delivered to the seller. The duplicate must be retained by the practitioner for at least two years after the original is delivered. Original and duplicate must be executed in ink or indelible pencil, or on a typewriter. The signature, address and registration number of the purchaser must correspond with his name, address and registration number as recorded in the collector's office, and the actual date of execution must be stated on the order form. The fact that order forms must be signed by the practitioner in whose name they are issued, before they are valid, tends to safeguard them against unauthorized use. The practitioner, however, should keep them under lock and key. The loss or theft of order forms should be reported as soon as it is discovered, to the Commissioner of Narcotics, Washington, D. C., stating the serial numbers of the missing blanks. If their numbers are not known, they should be described as accurately as possible, so as to facilitate action to prevent their unlawful use. A copy of the report should be sent to the collector of internal revenue by whom the blanks were issued.

DRUGS SHOULD BE GUARDED

Narcotic drugs should be kept under lock and key. When necessarily carried about in the course of practice, they should not be left where theft is easy, as in unlocked, unattended automobiles or in the dressing rooms of dispensaries and hospitals. If narcotic drugs are lost or stolen, or accidentally destroyed, the practitioner to whom they belong must make an affidavit, in duplicate, as to the kind and quantity of such drugs and the time and circumstances of the loss, theft or destruction. If the drugs were stolen, the affidavit should show that the local police authorities were promptly notified. One copy of the affidavit must be placed on file with the practitioner's duplicate order forms. The other must be filed with the narcotic agent in charge in the district in which the practitioner is registered. The address of the narcotic agent can be ascertained from the collector of internal revenue of the district.

When a practitioner makes his annual application for reregistration, he must prepare under oath or affirmation, in duplicate, an inventory of all narcotic drugs on hand at that time. The inventory must be executed in duplicate, on forms obtained from the collector of internal revenue for that purpose. The original inventory must be kept on file by the practitioner. The duplicate must be forwarded to the collector with the application for reregistration.

PRESCRIBING, DISPENSING REGULATIONS

General Considerations as to Administering, Dispensing and Prescribing.—A practitioner can

lawfully administer, dispense and prescribe narcotic drugs to only such patients as are under his professional care. The Harrison Narcotic Act does not limit specifically the quantity that may be used or the time during which their use may be continued. It requires only that the dosage be consonant with proper professional practice. It places no restriction on the form in which narcotic drugs may be administered.

The administration, dispensing and prescribing of narcotic drugs for the sole purpose of satisfying the cravings of an addict is not within the bounds of professional practice. That fact, however, does not prevent the continued use of narcotic drugs in such doses as may be found to be necessary to relieve the sufferings of a bona fide patient who has an incurable painful disease or to preserve the life of an aged and infirm addict whose life would be jeopardized by the withdrawal of his drug of addiction. A painful, incurable disease, or age and infirmity, must be present, however, to justify legally the indefinite continuance of the use of narcotic drugs. Instructions as to the form to be used in writing prescriptions in such cases are given later.

It is not unlawful under the Harrison Narcotic Act to attempt to cure narcotic addicts of their addiction, even though narcotic drugs are used in the attempt. If narcotic drugs are so used, the dosage from day to day must be accurately recorded. Unless there is a reasonably rapid reduction in the dosage and complete withdrawal within a short time, suspicion may rightly arise that the alleged attempt to cure is only a cover for the unlawful administration, dispensing or prescribing of narcotic drugs to satisfy the cravings of an addict. The best professional opinion seems to recognize the fact that an attempt to cure an addict outside the walls of a hospital or other institution is almost certainly doomed to failure and that attempts to cure under such circumstances can be justified, if they can be justified at all, only by some remarkable combination of circumstances.

BEWARE OF STRANGERS

A practitioner should not administer, dispense nor prescribe narcotic drugs for a stranger, unless there is obvious necessity, as in the case of a severe accident. To do so may be only to cater to addiction. It may result, too, in prosecution for violating the Harrison Narcotic Act, for the stranger in real or assumed distress may be in fact the agent of narcotic law enforcement officers.

If the story and subjective symptoms of a casual patient suggest the use of a narcotic drug and the practitioner can find no objective symptoms to justify its use, it is best to resort to other methods of relieving pain, relying on the fact that a casual patient who is seeking only to satisfy his narcotic addiction, or a stool pigeon, will not under such treatment long continue to return for treatment. If, however, the administration, dispensing or prescribing of a narcotic drug seems to be imperatively demanded, the minimum amount should be given that is compatible with the circumstances of the case and never more than is necessary to provide for the patient's needs until the practitioner can satisfy himself as to the good faith of the patient. A practitioner had better steel his heart against the wiles of a stranger who cannot prove a local residence or give references to former physicians and others, sufficient to prove his good faith promptly.

Administering Narcotic Drugs.—A practitioner can lawfully administer narcotic drugs personally to his patients, hypodermically, by mouth or otherwise, in any form or amount, with such frequency and for such a period of time as may be justified by good professional practice. It is no part of professional practice, however, to administer narcotic drugs for the sole purpose of catering to narcotic addiction. A practitioner is not required by law to keep a record of the narcotic drugs he administers. A record can do no harm, however, if the administration of such drugs is lawful, whereas its absence may prove embarrassing.

GOOD FAITH A FUNDAMENTAL FACTOR

Dispensing Narcotic Drugs.—A practitioner may lawfully dispense narcotic drugs personally to his patients. "To dispense," as the term is here used, means to supply narcotic drugs to a patient, to be taken by him out of the presence of the dispensing physician, as distinguished from the supplying of such drugs for immediate use by the patient in the presence of the practitioner by whom they are supplied.

A practitioner should avoid dispensing narcotic drugs, so far as is compatible with good professional practice in the community in which he is practicing. A too extensive resort to dispensing may justify a suspicion that the dispenser is only catering to narcotic addiction, unless the circumstances clearly show that dispensing is necessary. Under no circumstances should a greater quantity of narcotic drugs be dispensed than the minimum quantity required by existing conditions. The quantity should not exceed the quantity necessary to provide for the patient until he is to be seen again by the practitioner. If any greater quantity is called for, it should be provided through a prescription, so that the entire transaction may be a matter of record.

Only the most unusual conditions can justify a practitioner in delivering narcotic drugs directly to the patient for whose use they are intended. A person whose sufferings are aggravated and whose will is weakened by disease or injury should not be tempted to use narcotic drugs improperly, as he is tempted when such drugs are left with him, under his sole control, to be used

whenever he feels that they are needed. Narcotic drugs dispensed for a patient should be left in the custody of some competent and discreet nurse or other person in attendance on him. To prevent accidental poisoning, the person in whose custody they are left should be carefully instructed and duly cautioned. The drugs dispensed had better be placed in a suitable package or container, bearing instructions as to their use. Carelessness in dispensing may lead to accidental poisoning and a suit for malpractice.

ADVISABLE TO KEEP A RECORD

A record should be kept of all narcotic drugs dispensed. The provisions of the Harrison Narcotic Act relating to such record keeping are confused and seem to be not susceptible of rational interpretation. Section 2 of the Harrison Narcotic Act authorizes a physician, dentist or veterinary surgeon to dispense or distribute narcotic drugs "in the course of his professional practice only," and then provides: "That such physician, dentist, or veterinary surgeon shall keep a record of all such drugs dispensed or distributed, showing the amount dispensed or distributed, the date, and the name and address of the patient to whom such drugs are dispensed or distributed, *except such as may be dispensed or distributed to a patient upon whom such physician, dentist or veterinary surgeon shall personally attend;* and such record shall be kept for a period of two years from the date of dispensing or distributing such drugs, subject to inspection, as provided in this Act." Section 6 requires that a record be kept of all the so-called exempt preparations that a practitioner dispenses, but it does not require a record of the exempt preparations that he administers or prescribes.

The practitioner who keeps a record of all narcotic drugs that he dispenses will be safe against prosecution, no matter how the law may ultimately be interpreted. The record should show the kind and quantity of narcotic drugs or preparations dispensed, the name and address of the patient, and the date of dispensing. Entries should be made on the day when the drugs are dispensed. The record should be kept for not less than two years from the date of dispensing.

ADVICE RELATIVE TO PRESCRIBING

Prescribing Narcotic Drugs.—Prescriptions for narcotic drugs may lawfully be written on any prescription blank. Every such prescription must contain, however, the patient's full name and address and the prescriber's signature, address and registration number. Practitioners commonly have their registration numbers printed on their prescription blanks and provide spaces for the other required entries. Every prescription must be written in ink, with an indelible pencil, or on a typewriter. It must bear the full signature of the prescriber, such as he would use on a check or in a deed. Every prescription must be dated and signed on the day on which it is written. The quantity of the narcotic drugs prescribed should be stated with clearness and accuracy, so as to safeguard against alteration. The act does not require a practitioner to keep a record of his prescriptions for narcotic drugs. Unless his office system provides such a record, in the ordinary clinical records of his office, it may be well to keep one.

A prescription for narcotic drugs need not show the ailment or injury for which it is given. Under certain circumstances, however, the condition from which the patient is suffering must be disclosed in order to warrant a pharmacist in filling the prescription. Such disclosures are necessary only when prescriptions call for unusually large quantities or doses, or are repeated over unusually long periods of time. Prescriptions calling for unusually large quantities or doses, or repeated over unusually long periods of time, justify the presumption that they are for the use of a narcotic addict. They leave pharmacists in doubt as to whether they are given solely to satisfy the cravings of narcotic addicts, in which case pharmacists cannot lawfully fill them, or are given for legitimate medical purposes. The law recognizes only two conditions under which such prescriptions can be given for legitimate medical purposes, and, unless they bear some evidence of having been given for one or the other of such purposes, pharmacists may refuse to fill them.

EXCEPTIONS CAN BE INDICATED

If prescriptions are given for unusually large quantities or doses of narcotic drugs, or are repeated over unusually prolonged periods of time, for a patient suffering from an incurable disease, such as advanced cancer, advanced tuberculosis, and other diseases well recognized as coming within that class, the physician should indicate the purpose of the prescription by endorsing on it that the drug is for the treatment of an incurable disease, or he may indicate that fact by the endorsement, "Exception (1), Art. 85." If such a prescription is for the purpose of supplying narcotic drugs for an aged and infirm addict whose collapse would result from the withdrawal of his accustomed doses of narcotic drugs, that fact should be indicated by endorsing on it the statement that the patient is aged and infirm, stating the age, or by endorsing on it, "Exception (2), Art. 85." The continued use of narcotic drugs, within reasonable professional limits, in either of such classes of cases is lawful, even though it may maintain or create narcotic addiction. Such endorsements as have been described serve to indicate the lawfulness of the prescriptions on which they appear and to distinguish them from unlawful prescriptions, given for the sole purpose of satisfying the cravings of narcotic addicts.

A physician should safeguard his prescription blanks, to prevent their falling into unauthorized hands. The genuineness of a prescription blank is in last analysis proved by the signature it bears. Every druggist, however, cannot be familiar with the signature of every physician whose prescriptions may be presented to him to be filled. He must rely, at least in part, on the fact that a narcotic addict or peddler is not likely to provide himself with the printed prescription blanks of a registered practitioner. A prescription written on such a blank is therefore ordinarily presumed to be genuine. Hence the necessity for preventing prescription blanks from falling into improper hands.

TELEPHONE PRESCRIBING BANNED

A pharmacist cannot lawfully dispense narcotic drugs on telephoned instructions. If a practitioner cannot leave with his patient necessary narcotic drugs, and if the patient cannot send to a pharmacist a prescription for such drugs, the physician may telephone to the pharmacist such directions as may be necessary to enable him to compound the prescription. At the same time the physician should leave with his patient a corresponding written prescription for them. The pharmacist can then compound and dispense the needed narcotic drugs and send them by messenger to the patient. The messenger, however, must make sure before he delivers the drugs that he has in his possession a bona fide prescription for them. If a physician is called on at his office or elsewhere, by telephone or otherwise, to prescribe for a patient with whose condition he is familiar, and if he believes that his patient needs a narcotic drug, he may follow the course just outlined, having the pharmacist's messenger obtain the written prescription at the practitioner's office or at some other designated place, before he delivers the drugs to the patient. The messenger carrying the narcotic drugs must be a bona fide agent of the pharmacist, so that from a legal standpoint the drugs do not pass out of the pharmacist's lawful possession before the prescription is delivered into it.

A prescription for a narcotic drug cannot lawfully be refilled, unless it is for one of the so-called exempt preparations or calls for a mixture in which the narcotic content does not exceed the narcotic content allowed by law in such preparations. Prescriptions coming within either of these two exceptions can lawfully be refilled, unless the prescribing practitioner has otherwise directed, if the refilling is in good faith, for medicinal purposes, and not for the purpose of evading the provisions of the Harrison Narcotic Act.

Narcotic Addicts.—The Harrison Narcotic Act is silent as to the treatment of narcotic addicts. A physician who contemplates treating any such patient, however, should inform himself fully as to the laws of the state in which the treatment is to be given, before he enters on that course. Treatment outside of a thoroughly dependable institution, well organized for that purpose, is hardly justifiable, even though it is lawful. In any case, whether in or out of an institution, careful records should be kept of all medication. If narcotic drugs are not withdrawn at the outset, the record should show a continual and reasonably rapid diminution in the dose, and a comparatively early total withdrawal.

DIFFICULTIES WITH ADDICTS

The apparently rapid and easy withdrawal of the drug of addiction should not be accepted too readily as a sign of the success of treatment. It may be evidence only that the patient is procuring a drug supply from some other source. If he is at large, he may be obtaining it from one or more other physicians, who are simultaneously treating him for the supposed cure of his habit, each without knowledge of the fact that his patient is under treatment by other practitioners.

If prescriptions for unusually large quantities or doses of narcotic drugs, or prescriptions for any quantity and dose over an unusually long period of time, for a single patient from a single physician, appear in the files of local pharmacists, the narcotic officers in the district will presumably institute an inquiry to determine the circumstances under which they are being issued. The filing of order blanks for narcotic drugs in unusual quantities, with wholesale dealers, by a single physician, may lead to a similar inquiry. A physician who prescribes or orders such drugs should be prepared to meet any such inquiry. It may be better, if the addict-patient under treatment consents, to report the circumstances to the local narcotic officers when beginning treatment, so as to forestall suspicion and misunderstanding.

EXEMPT PREPARATIONS

Exempt Preparations.—When the Harrison Narcotic Act was passed, it exempted from its provisions certain more or less attenuated narcotic preparations and certain other narcotic preparations not susceptible of use internally, when manufactured, sold, distributed, given away, dispensed or possessed as medicine and not with the intention of evading the provisions of the act. Later, the act was amended so as to require any manufacturer, producer, compounder or vender, including dispensing physicians, to register and to keep a record of all sales, exchanges or gifts of such theretofore exempt preparations. Physicians are thus placed in an anomalous position. They may administer and prescribe narcotic drugs of any kind without any statutory obligation as to record keeping. Their statutory obligation as to record keeping with respect to the potent narcotic drugs they dispense is, to say the least, obscure. But if they dispense any of the more attenuated

narcotic drugs—so attenuated as to exempt them from the general provisions of the law—they must keep a record showing the date of the sale or gift, the name and address of the purchaser, and the name and quantity of the preparation.

The so-called exempt narcotic drugs comprise such as contain not more than 2 grains of opium, or one-fourth grain of morphine, or one-eighth grain of heroin, or 1 grain of codeine, or of any salt or derivative of any of them, in 1 fluid ounce, or, if a solid or semisolid preparation, in 1 avoirdupois ounce, and liniments, ointments and other preparations prepared for external use only, which contain no cocaine nor any of its salts, nor alpha or beta eucaine or any of their salts, or any synthetic substitute for them. An exempt preparation must contain active medicinal agents other than narcotic drugs, in sufficient proportions to give the preparation medicinal qualities in addition to those of the narcotic drugs alone.

SPECIAL REGISTRATION

A practitioner who desires to dispense any of the exempt preparations must register specially for that purpose. If he is already registered as a practitioner authorized to administer, dispense and prescribe narcotic drugs generally, he may register as a dispenser of exempt preparations, without the payment of an additional tax. If he desires to register only as a dispenser of exempt preparations, however, which is hardly likely to be the case, he must pay an annual tax of $1. This tax is payable in the same manner as are other taxes imposed by the Harrison Narcotic Act.

The so-called exempt preparations may be purchased by any one like any other drug, from any pharmacist or other dealer authorized to deal in them. The use of such order forms as are required for the purchase of narcotic drugs generally, or of any other form, is not necessary. The exempt preparations can be prescribed as other drugs are prescribed, without necessarily stating the name and address of the patient, the prescriber's registration number, or other particulars. Such prescriptions can be lawfully refilled, unless they bear directions from the prescribing practitioners forbidding refilling.

Possession of Narcotic Drugs by Patients.—The unexplained possession of narcotic drugs raises a presumption of unlawfulness. To explain possession when they have been prescribed by a physician and to rebut that presumption, the bottle or other container in which the drug has been dispensed must bear the name and registry number of the druggist, serial number of prescription, name and address of the patient, and the name, address and registry number of the practitioner who wrote the prescription.

Penalties.—A person who violates any provision of the Harrison Narcotic Act is liable to be fined not more than $2,000, or to be imprisoned for not more than five years, or both, in the discretion of the court. The Commissioner of Narcotics, however, with the advice and consent of the Secretary of the Treasury, may compromise any civil or criminal case arising under the act, instead of commencing suit thereon.

Failure to pay the required tax within the time limit prescribed by the act adds a penalty of 25 per cent to the tax when it is paid. The Commissioner of Narcotics may waive this penalty if good cause is shown for doing so.

Under the laws of some states, conviction of a violation of the Harrison Narcotic Act is a ground for the suspension or revocation of a license to practice medicine. When the state law does not contain this provision, it sometimes accomplishes the same end by authorizing the suspension or revocation of licenses on conviction of any felony, for a violation of the Harrison Narcotic Act is a felony.

—OSMJ—

Dr. Sutton, Zanesville, Feted as He Completes 50 Years of Practice

In recognition of his 50 years of active service to the community, a testimonial dinner was given April 1 at the Good Samaritan Hospital, Zanesville, honoring Dr. H. T. Sutton, who on April 1, 1885, opened an office there for the practice of medicine, following his recent graduation from the Ohio Medical College, Cincinnati.

The banquet was sponsored by the Franciscan Order, in charge of Good Samaritan Hospital, which hospital owes its existence largely to the active interest of Dr. Sutton during the past three or four decades.

In 1905, Dr. Sutton took the lead in raising funds for converting a private sanitorium into what is now one of the high ranking hospitals of the state. He served the hospital for many years as chief of staff and was instrumental in securing additions and betterments for the institution from time to time.

Dr. Sutton, in addition to being one of the leading members of the medical profession in his community, has been for many years a civic leader. He was Zanesville's first director of public health and sanitation. Under Governor Harmon he served as a member of the State Board of Health. Dr. Sutton always has been active politically, having been a delegate on several occasions to the National Democratic Convention.

Dr. W. D. Coffman served as toastmaster at the dinner which was attended by many of Dr. Sutton's friends in the medical profession and among the laity.

Among those who addressed the gathering were: Drs. I. B. Harris and Joseph Price, of Columbus; A. L. Pritchard, Nelsonville; and W. A. Melick, C. M. Rambo and E. R. Brush, Zanesville.

ORGANIZED MEDICINE AND THE DOCTOR OF MEDICINE

Radio Address by Dr. Farmer, Dayton. An Example of the Kind of Information Which May be Presented by Physicians in Talks Before Lay Gatherings

NOW, more than ever before, members of the medical profession are being called upon to discuss at public gatherings the great benefits of scientific medicine, new discoveries in the field of medical science and the various social and economic problems arising from disabling sickness and affecting the practice of medicine.

For that reason, physicians must be accurately informed and prepared to present such information in a comprehensive manner.

Recently the *Dayton Daily News*, in inaugurating its new radio station, WHIO, presented a program by representatives of various business and professional groups of Dayton.

One of the speakers was Dr. A. G. Farmer, president of the Montgomery County Medical Society. The subject of his address, which was presented in question and answer form, was "Organized Medicine and The Doctor of Medicine".

Dr. Farmer's dialogue with the radio announcer is herewith published in part, as an example of the type of public address the average physician in any community can deliver to lay groups to give them a better understanding of the aims and ideals of the medical profession, its educational standards and the great things scientific medicine has accomplished.

It is hoped that many physicians will avail themselves of opportunities of this kind and arrange their presentations in somewhat the same way Dr. Farmer did.—*Editorial Note.*

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Q. Doctor, we hear much recently of "Organized Medicine". Can you explain to us something of the real meaning of "Organized Medicine"?

A. Organized Medicine has many aims and ideals. It is a brotherhood of doctors of medicine affiliated for study and the advancement of medical knowledge, and for the upholding of standards of professional ethics and the study and dissemination of information on questions of legislation, economics and public relations affecting the practice of medicine.

Q. What does the term "Doctor of Medicine" signify?

A. Doctors of Medicine are men and women who, after completing the prescribed amount of educational training in an accredited university and college of medicine, have conferred upon them by the college authorities the degree of doctor of medicine. This prescribed educational training includes an adequate general education of at least four years in high school and two years in an approved college of arts and sciences in addition to at least four years in an accredited college of medicine. Many Class A medical schools now require as a preliminary training a university degree in liberal arts before the applicant is admitted to medical school. These pre-medical requirements are necessary for the reason that a certain amount of knowledge of the basic sciences and trained mental capacity are essential to the study and understanding of the highly technical and scientific subjects given in training the medical student. After being accepted as a student in a medical college, the young man or young woman must complete four full years of study in the medical sciences and in clinical training. Many medical colleges now are requiring one or more years of internship in an approved hospital before conferring the degree of doctor of medicine. Practically all medical school graduates complete hospital internships before entering practice. This intern training is important since it provides for the practical application of the training received in the classroom under the supervision and direction of experienced staff physicians. After he completes his internship, the medical student is required to pass the examinations of the State Medical Board. He is now, at last, ready to enter the practice of his profession, a competent and well-trained physician. So, when you call a doctor of medicine to attend you or your family in case of illness, you may in most instances rest assured that you are in the hands of a safe, trained physician, and will

receive the benefits of the best medical knowledge.

Q. I presume this young physician is now ready to affiliate with organized medicine. Will you explain how and why he takes this step?

A. The young physician entering upon the practice of his profession first seeks, by application, to become a member of his county medical society. Membership in his county medical society automatically makes him a member of the Ohio State Medical Association and the American Medical Association. This membership establishes his professional standing and his relationship to his fellow physicians, and insures his acceptance by the hospitals as competent to be privileged to treat his patients in a hospital when necessary.

Q. Are there any other benefits derived from affiliation with Organized Medicine?

A. There are many benefits additional to the purely personal advantages. Very early in the history of medicine physicians found that isolation and strict individualism was not possible if they desired to keep abreast of the latest medical knowledge, and if they wished to conform to high standards of medical practice and professional behavior. A physician does not cease to be a medical student when he leaves college. If he would be a successful physician he must be a medical student for the balance of his active life. Advancement in knowledge of medicine and surgery and the new, previously unknown facts which are constantly coming to light through the efforts of research make this essential. So the doctors early formed groups which met at regular intervals for the purpose of hearing essays and having discussions on medical and surgical subjects, particularly the newer developments in method and therapeutic agents. These early groups developed into what is now the county medical society, one in each county of each state. These combined county societies form their respective state societies, and the combined state societies form the American Medical Association.

Q. What are some of the activities of the American Medical Association?

A. The American Medical Association first became a definite organization in 1847. Its purpose was to hold regular meetings once yearly, at which time scientific papers on medical and surgical subjects were read and discussed, new methods and procedures of diagnosis and treatment studied, and other questions of interest to doctors considered. The American Medical Association now, in addition to these meetings, maintains an extensive headquarters in Chicago, publishes a number of periodicals devoted to medicine and surgery, operates research laboratories for the analysis and study of medicines, drugs, foods and therapeutic appliances. The Association also makes a study of, and recommendations for, medical economics, ethics, legislation, and standards of hospital management, medical education, etc. These are some of the constant activities of organized medicine in its efforts to give to the American people the advantages of the latest and safest medical knowledge in their time of need, and to protect their health and lives by the prevention of illness and the control and prevention of the terrible epidemics which took such heavy toll of the lives of our forefathers, before we had the knowledge of their nature which is now at our disposal.

Q. Doctor, what were some of those dangerous epidemics to which you refer?

A. Before modern methods of research and experiment and what is known in history as the "experimental method" of finding out about the cause of such happenings and whether there was a way to prevent them, men considered such epidemics as a visitation of "fate" and a punishment for their sins. Those of my listeners who have been interested in reading history know that during times of great and widespread disease whole populations of entire countries sickened and died, whole families were wiped out within a few days and their friends and the authorities stood by helpless, not knowing the cause or nature of the rapid spread of such disease. They could do nothing but hope and pray. The doctors of the time did what they could to help, after the victim was stricken, and many heroic stories are written about their devotion to duty, but they knew nothing about cause and prevention and mighty little about specific treatment. Some examples of such disasters which are commonly found in current history are the great plague which swept Europe in the 17th century, which decimated whole populations, threw whole cities into frightened panic and disrupted the normal life and daily pursuits of every individual. Through methods of research and study, by men of medical science, we know now that the great plague was spread and caused by man's common animal enemy, the rat, and the fleas which live on him. We know that to keep down the rat, and prevent his contact with humans, we will never again go through the horror of an epidemic of plague. Though they did not know it, the great fire of London, so well described by Samuel Pepys, was a great blessing. It occurred during the time of plague, destroyed a great part of the City of London, and thus destroyed or drove out the myriads of rats in the old buildings, and so did more to stop the plague than all the doctors or all the edicts of Kings could do. Smallpox, before the 18th century, was a universal disease in the known civilized world. A great many of the stricken died, and very few of either high or low degree were seen without the disfiguring scars of

the dread disease. In about 1765 an observing doctor named Edward Jenner, without scientific laboratories or endowments, noticed that the milkmaids of rural England, where he practiced, sometimes acquired mild attacks of cowpox in the course of their occupation, and that thereafter, no matter how much they were exposed to the dread smallpox, they did not get the disease. Reasoning from this observation he deliberately infected some persons with the mild and harmless cowpox and then watched their tendency to acquire smallpox when in contact with that disease. Such persons never became ill with smallpox. From this work of a rural practitioner developed vaccination against smallpox.

Q. Then if properly carried out, vaccination is positive protection and has delivered the world from the miseries of one of its most destructive plagues?

A. Yes. That is right.

Q. The doctors of our own United States have taken large part in freeing the world of destructive epidemics. Will you tell us something of their work?

A. Within the memory of many now alive and in the time of our own grandparents, yellow fever, commonly known as "Yellow Jack", was a frequent and fatal visitor to our southern states. Such cities as New Orleans, Memphis, Richmond, Va. and even as far north as Philadelphia, were regularly visited by widespread and fatal epidemics of Yellow Fever, which is a term without much interest or meaning to us today. Accounts of the last great epidemic of Yellow Fever in Philadelphia tell of the horrors of the dead lying in the streets and the sick unattended, and all normal activities of life disrupted because of panic and fear. All this happened during the lives of our own grandparents. Physicians were helpless, they knew neither the cause nor the method of spread of the great disease. Then, as recently as 1900, occurred the dramatic and heroic work of a group of American Army doctors in Cuba, that is as inspiring a tale as any romance of all history. The theory that Yellow Fever might be carried by insects, probably mosquitoes, had been long mentioned. Under the inspired direction of Major Walter Reed, a medical officer of the United States army, experiments were carried out in Cuba to prove or disprove this theory. At the cost of some lives devoted to the cause of medical science it was proven beyond any doubt, that Yellow Fever could be spread by one means only and that was by a mosquito. Therefore, protect all people from the mosquito and the dread yellow fever would disappear. The truth of this heroic and spectacular work has been proven until now yellow fever is merely a word and not a deadly menace.

These are only a few of the results of the constant labors of doctors of medicine in the interests of humanity, many others could be described if time permitted, such as very recent discoveries of insulin in the control of diabetes and the control of pernicious anemia and many others. So please look upon your physician, the doctor of medicine, with a kindly thought of his efforts to keep you well and happy.

Q. Doctor, I understand you spent a number of years in the Panama Canal Medical Service. Can you tell us something about the work of American physicians there?

A. Long before the U. S. Government became actively interested in Panama, the French Government, encouraged by its success in constructing the Suez Canal, decided to attempt the construction of a ship canal across the Isthmus of Panama. French engineers and the necessary army of white employees and materials were assembled. The work was begun, and very material progress was made, though the difficulties were enormous.

One of the major difficulties was the inability of the white imported workers to withstand the ever present tropical diseases. The death rate was enormous, and Panama soon become known as the pest hole of the Tropics. Doctors and sanitarians of that time had no accurate knowledge of the causes and methods of control of the fatal tropical diseases.

Yellow fever, malarial fever and dysentery were chief among the causes of the white man's high death rate. Finally this was one of the major reasons for the French abondoning the canal construction. Then the United States took over the project. Its first and most important activity was the formation of a Health Department of American Doctors of Medicine, under the supervision of General Wm. C. Gorgas, who had much to do with the yellow fever and mosquito experiments in Cuba.

These Doctors, armed with more recent and exact knowledge of disease control, began the work of controlling and stamping out the diseases that had proven so fatal to the French.

The results of the experiments of the American Doctors in Cuba were so exact that similar methods of control in Panama, within a year, reduced yellow fever to an occasional case, and soon made it as rare a disease as it now is in this country. By an application of the medical knowledge constantly being brought forth, the results with other diseases were just as successful. Today the health of Panama, the former "pest spot" compares favorably with any health resort, in the world.

These are a few of the accomplishments, without the aid of cults, of the Science of Medicine, and no other school or system can show such positive results for the well-being of humanity.

Dr. Blankenhorn Appointed Head of Department of Internal Medicine, University of Cincinnati

Dr. Marion A. Blankenhorn, since 1929 professor of clinical medicine, School of Medicine, Western Reserve University, has been selected by the Board of Trustees, University of Cincinnati, as head of the department of internal medicine and Taylor professon of internal medicine at the College of Medicine, University of Cincinnati.

Dr. Thomas D. Spies, Dr. Blankenhorn's associate at Western Reserve University, will accompany him to Cincinnati and become assistant professor of internal medicine.

Both appointments will take effect September 1.

A native of Orrville, Ohio, Dr. Blankenhorn received the degree of Ph. B. at Wooster College in 1909, the degree of Doctor of Medicine in 1914, and the degree of Master of Arts in 1920, both from Western Reserve. During the war he served in the United States and France.

After the war, Dr. Blankenhorn became instructor in medicine at Western Reserve, leaving in 1925 to serve as special investigator for one year at Rockefeller Institute, where he held the rank of Associate.

In 1926 he became associate professor of medicine and in 1929 professor of clinical medicine at Western Reserve. Dr. Blankenhorn has published researches on the diseases of the circulation, shock, various types of liver disease and of fungus infection, and the physiology of biliary pigments.

Dr. Spies was graduated from the University of Texas in 1923 with the degree of bachelor of arts. He took his professional training at Harvard Medical School, receiving the doctor of medicine degree in 1927. Since 1931 Dr. Spies has been with the teaching staff of Western Reserve.

The Board at its recent meeting announced the acceptance of an anonymous gift of $22,000 for improvements in the urological and radiological services at Cincinnati General Hospital.

It approved the plan suggested by Dr. Alfred Friedlander, dean of the College of Medicine, for offering special summer courses for graduates of the college. Such "refresher" course will be offered in internal medicine and allied branches from June 24 through July 20.

Several advancements in rank among members of the College of Medicine faculty were approved. These follow: Dr. A. W. Foertmeyer, Dr. D. A. Johnston, and Dr. C. E. Shinkle, from instructor to assistant professor of psychiatry; Dr. E. A. Baber and Dr. W. N. Wright, from assistant to instructor in psychiatry.

The following appointments were approved: Dr. Henry Thomason, lecturer on anaesthesia; Dr. Calvin Elton Richards, resident physician; Dr. Hunt Cleveland, Dr. Charles Allison, Dr. Carl Adam Hartung, Dr. Helen Iglauer Glueck, Dr. Edward John Geiser, Dr. David Lloyd Graller, Dr. Arthur Jesse Merrill, Dr. Herman John Nimitz, and Dr. Earl Cornelius Van Horn, assistant resident physicians; Dr. Gerrit W. Raidt, clinician in the pediatric out-patient clinic; Dr. David A. Tucker, consulting physician to the Contagious Hospital; Dr. Carl W. Koehler, instructor in radiology; Dr. Azel Ames and Dr. Harry Fry, instructors in surgery; Dr. Josiah Smith, Dr. Alois Moore, Dr. Edward McGrath, Dr. Jean Stevenson, Dr. Henry Lee, Dr. Daniel Earley, Dr. J. J. Longacre, Dr. Harvey McCandless, Dr. Vinton Siler, Dr. Paul Hoxworth, Dr. James Mack, and Dr. Paul Merrell, assistants in surgery.

Dr. A. Miller, instructor and resident in orthopedic surgery; Drs. Robert Bowman, Charlotte M. Johnson, Daniel V. Jones, Clyde Dummer, Robert J. McGillicuddy, and James W. Sterling, assistants in pediatrics; Drs. Edward Canipelli, James J. Thompson, Ronald J. McNamara, Stuart A. Schloss, and Ralph J. Johansmann, Assistants in pathology; Dr. Philip Piker, Alfred M. Stern, assistant professor of psychiatry; Dr. John C. Danahy, instructor in pediatrics.

Resignations were accepted from Dr. Earle V. Ferguson, instructor in surgery, College of Medicine, effective June 30, and Dr. Robert Tapke, assistant in surgery, effective June 30. Dr. William M. Peake, Alfred M. Stern assistant professor of psychiatry, June 30; Dr. Harry H. Haggart, assistant in oto-laryngology and attending oto-laryngologist and clinician, General Hospital; Dr. Robert Perlman, instructor in orthopedic surgery, August 31.

— OSMJ —

A city board of health may not expend funds distributed to it under Section 1080-17 of the Milk Commission Act unless such funds are first appropriated by the city council in compliance with other sections of the General Code, Attorney General John W. Bricker ruled recently in replying to an inquiry made by the State Department of Health.

— OSMJ —

Zanesville—Dr. P. H. Elliott, graduate of the College of Medicine, University of Cincinnati, has opened offices here.

Ashtabula—The history of medicine was summarized by Dr. W. J. McCarthy in an address before the local Kiwanis Club.

Cincinnati—Dr. H. O. Lepsky, formerly of New Richmond, has become an associate of Dr. Henry B. Freiberg.

Quaker City—Dr. Frank J. Lacksen attended the 14th annual post-graduate course at the University of Buffalo Medical School.

Ravenna—Dr. A. J. Silberger, formerly of Randolph and a graduate of St. Louis University School of Medicine, has opened offices here.

Cincinnati—Announcement has been made of the marriage of Miss Rosemarie Brinck, Dayton, and Dr. John M. Karch, this city.

U. S. SUPREME COURT UPHOLDS OREGON STATUTE TO CURB UNPROFESSIONAL ADVERTISING

THE United States Supreme Court on April 1, 1935, rendered a decision in the case of Harry Semler, Appelant, vs. the Oregon State Board of Dental Examiners, etc., which will have an important and beneficial effect on the official actions of professional licensing boards in attempting to curb unprofessional conduct, protect the public from fraud and quackery, and maintain high standards among the professions engaged in ministering to the medical and health needs of the public.

The decision, delivered by Mr. Chief Justice Hughes, in effect held that the Oregon statute placing stringent restrictions on unethical and misleading self exploitation by dentists is not repugnant to the due process and equal protection clauses of the Fourteenth Amendment and does not impair the obligation of contracts.

Because of the pertinent language used in the opinion and its importance, the opinion is herewith published in full.

"This case presents the question of the validity of a statute of the State of Oregon, enacted in 1933, relating to the conduct of dentists. Oregon Laws, 1933, Chapter 166. Previous legislation had provided for the revocation of licenses for unprofessional conduct, which, as then defined, included advertising of an untruthful and misleading nature. The Act of 1933 amended the definition so as to provide the following additional grounds for revocation: 'advertising professional superiority or the performance of professional services in a superior manner; advertising prices for professional service; advertising by means of large display, glaring light signs, or containing as a part thereof the representation of a tooth, teeth, bridge work or any portion of the human head; employing or making use of advertising solicitors or free publicity press agents; or advertising any free dental work, or free examination; or advertising to guarantee any dental service, or to perform any dental operation painlessly.'

"Plaintiff, a dentist practicing in Portland, Oregon, brought this suit in the state court against the members of the State Board of Dental Examiners to enjoin the enforcement of the statute, alleging that it was repugnant to the due process and equal protection clauses of the Fourteenth Amendment, and impaired the obligation of contracts in violation of Section 10, Article I, of the Constitution of the United States. The circuit court, overruling this contention, sustained a demurrer to the complaint and, upon the refusal of plaintiff to plead further, the suit was dismissed. On appeal, the Supreme Court of the State took the same view of the federal question and affirmed the judgment. 34 Pac. (2) 311. The case comes here on appeal.

"Plaintiff alleged in his complaint that he was licensed in 1918; that he had continuously advertised his practice in newspapers and periodicals, and by means of signs of the sort described in the amended statute, and that he had employed advertising solicitors; that in his advertisements he had represented that he had a high degree of efficiency and was able to perform his professional services in a superior manner; that he had stated the prices he would charge, had offered examinations of prospective patients without charge, and had also represented that he guaranteed all his dental work and that his dental operations were performed painlessly. He further alleged that the statements in his advertisements were truthful and were made in good faith; that by these methods he had developed a large and lucrative practice; that through long training and experience he had acquired ability superior to that of the great majority of practicing dentists; that he had been able to standardize office operations, to purchase supplies in large quantities and at relatively low prices, and thus to establish a uniform schedule of charges for the majority of operations; also that he had made contracts for display signs and for advertisements in newspapers, and had entered into other engagements, of which he would be unable to take advantage if the legislation in question were sustained, and, in that event, his business would be destroyed or materially impaired.

"Plaintiff is not entitled to complain of interference with the contracts he describes, if the regulation of his conduct as a dentist is not an unreasonable exercise of the protective power of the State. His contracts were necessarily subject to that authority. *Rast v. Van Deman & Lewis, 240 U. S. 342, 363; Union Dry Goods Co. v. Georgia Public Service Commission, 248 U. S. 372, 375, 376; Sproles v. Binford, 286 U. S. 374, 391; Stephenson v. Binford, 287 U. S. 251, 276.* Nor has plaintiff any ground for objection because the particular regulation is limited to dentists and is not extended to other professional classes. The State was not bound to deal alike with all these classes, or to strike at all evils at the same time or in the same way. It could deal with the different professions according to the needs of the public in relation to each. We find no basis for the charge of an unconstitutional discrimination. *Watson v. Maryland, 218 U. S. 173, 179; Miller v. Wilson, 236 U. S. 373,*

384; Missouri ex rel. Hurwitz v. North, 271 U. S. 40, 43; Dr. Bloom, Dentist, Inc. v. Cruise, 288 U. S. 588.

"The question is whether the challenged restrictions amount to an arbitrary interference with liberty and property and thus violate the requirment of due process of law. That the State may regulate the practice of dentistry, prescribing the qualifications that are reasonably necessary, and to that end may require licenses and establish supervision by an administrative board, is not open to dispute. *Douglas v. Noble, 261 U. S. 165; Graves v. Minnesota, 272 U. S. 425, 427.* The State may thus afford protection against ignorance, incapacity and imposition. *Dent v. West Virginia 129 U. S. 114, 122; Graves v. Minnesota, supra.* We have held that the State may deny to corporations the right to practice, insisting upon the personal obligations of individuals (*Miller v. State Board of Dental Examiners, 90 Colo. 193, 287 U. S. 563*), and that it may prohibit advertising that tends to mislead the public in this respect. *Dr. Bloom, Dentist, Inc. v. Cruise, 259 N. Y. 358, 363; 288 U. S. 588.*

"Recognizing state power as to such matters, appellant insists that the statute in question goes too far because it prohibits advertising of the described character, although it may be truthful. He contends that the superiority he advertises exists in fact, that by his methods he is able to offer low prices and to render a beneficial public service contributing to the comfort and happiness of a large number of persons.

"The state court defined the policy of the statute. The court said that while, in itself, there was nothing harmful in merely advertising prices for dental work or in displaying glaring signs illustrating tooth and bridge work, it could not be doubted that practitioners who were not willing to abide by the ethics of their profession often resorted to such advertising methods 'to lure the credulous and ignorant members of the public to their offices for the purpose of fleecing them.' The legislature was aiming at 'bait advertising.' 'Inducing patronage,' said the court, 'by representations of painless dentistry,' 'professional superiority,' 'free examinations,' and 'guaranteed dental work' was, as a general rule, 'the practice of the charlatan and the quack to entice the public.'

"*We do not doubt the authority of the State to estimate the baleful effects of such methods and to put a stop to them. The legislature was not dealing with traders in commodities, but with the vital interest of public health, and with a profession treating bodily ills and demanding different standards of conduct from those which are traditional in the competition of the market place. The community is concerned with the maintenance of professional standards which will insure not only competency in individual practitioners, but protection against those who would prey upon a public peculiarly susceptible to imposition through alluring promises of physical relief. And the community is concerned in providing safeguards not only against deception, but against practices which would tend to demoralize the profession by forcing its members into an unseemly rivalry which would enlarge the opportunities of the least scrupulous. What is generally called the 'ethics' of the profession is but the consensus of expert opinion as to the necessity of such standards.*

"It is no answer to say, as regards appellant's claim of right to advertise his 'professional superiority' or his 'performance of professional services in a superior manner,' that he is telling the truth. In framing its policy the legislature was not bound to provide for determinations of the relative proficiency of particular practitioners. The legislature was entitled to consider the general effects of the practices which it described, and if these effects were injurious in facilitating unwarranted and misleading claims, to counteract them by a general rule even though in particular instances there might be no actual deception or misstatement. *Booth v. Illinois, 184 U. S. 425, 429; Purity Extract Company v. Lynch, 226 U. S. 192, 210; Hebe Company v. Shaw, 248 U. S. 207, 303; Pierce Oil Corporation v. Hope, 248 U. S. 498, 500; Euclid v. Ambler Company 272 U. S. 365, 388, 389.*

"The judgment is affirmed."

—OSMJ—

Columbus Superintendent New Head of Ohio Hospital Association

Dr. M. F. Steele, superintendent of Grant Hospital, Columbus, was elected president of the Ohio Hospital Association at the annual meeting of the association, held in Columbus, April 2-4.

Other officers elected are: Dr. Mary Ware, Cleveland, first vice president; Sister Mary Carmollita, Cleveland, second vice president; Rt. Rev. M. F. Griffin, Cleveland, treasurer, and A. E. Hardgrove, Akron, executive secretary.

Meeting jointly with the hospital association were the following organizations: Ohio Dietetic Association, Ohio Association of Record Librarians, Ohio Association of Nurse Anesthetists, and Hospital Obstetric Society of Ohio.

Among the guest speakers were Robert Kolly, Houston, Texas, president of the American Hospital Association; Dr. R. C. Buerki, Madison, Wisconsin, president-elect of the American Hospital Association; J. Dewey Lutes, Chicago, director of the American College of Hospital Administrators, and A. B. Mills, editor of *The Modern Hospital.*

Dr. E. P. Gillette New President of Northern Tri-State Society

Dr. E. P. Gillette, Toledo, was elected president of the Northern Tri-State Medical Association, at the annual meeting of the association, held in Lima, April 9.

Other officers elected were: Dr. G. E. Jones, Lima, vice president; Dr. W. E. Kelly, Laporte, Indiana, secretary, and Dr. W. H. Marshall, Flint, Michigan, treasurer.

It was voted to hold the 1936 meeting at Fort Wayne, Indiana.

Among those who addressed the meeting were: Drs. R. Wesley Scott, Cleveland; John Walker Moore, Louisville, Kentucky; H. E. Randall, Flint, Mich.; William Bartlett, Sr., Washington University; R. L. Schaefer, Detroit, Mich.; B. H. Nichols, Cleveland; R. W. Waggoner, University of Michigan; Irving W. Potter, Buffalo, N. Y.; Martin H. Fischer, University of Cincinnati; Alan Brown, University of Toronto; Ralph A. Kinsella, St. Louis School of Medicine; Max Cutler, Chicago; and Emil Novak, University of Maryland.

—OSMJ—

Second Post Graduate Program Given On April 17 at Akron

The second of a series of "post-graduate" days, arranged by the Summit County Medical Society, was held at the Peoples Hospital, Akron, on Wednesday afternoon and evening, April 17. The following program was presented:

1:30 P. M.—1. "Compression Fractions of the Spine", Dr. F. B. Roberts.

2. "Pneumonia"—A Symposium: Etiology and Pathology, Dr. F. C. Potter; Clinical Symptoms and Diagnosis, Dr. C. E. Held; Treatment, Dr. O. P. Allen.

3. "Bronchial Asthma"—A Demonstration, Dr. K. D. Way.

6:30 P. M.—Dinner.

7:15 P. M.—1. "Birth Injuries", Dr. L. L. Bottsford.

2. "Hodgkins Disease"—A Symposium: Etiology and Pathology, Dr. F. C. Potter; Clinical Symptoms and Diagnosis, Dr. E. B. Dyson; X-Ray Findings and X-Ray Treatment, Dr. E. L. Voke.

3. "Otitis Media", Dr. J. E. Springer.

The committee from the Peoples Hospital Staff in charge of the program consisted of: Dr. F. C. Potter, chairman; Drs. J. E. Springer, J. G. Blower, L. L. Bottsford and J. C. McClelland.

Fifth District to Hold Annual Meeting and Program in Cleveland on Friday, May 17

Annual meeting of the Fifth District of the Ohio State Medical Association will be held Friday, May 17, at the Allen Memorial Medical Library, Euclid Avenue and Adelbert Road, Cleveland.

Large delegations of the counties of the district are planning to attend.

The program, being arranged by Dr. A. A. Jenkins, Councilor of the Fifth District, and Dr. H. V. Paryzek, is tentative as follows:

"The Treatment of Toxemia of Pregnancy and Eclampsia", Dr. J. L. Reycraft, Cleveland.

"Treatment of the Commoner Fractures", Dr. Russell H. Birge, Cleveland.

"Management of Hypertension", Dr. H. C. King, Cleveland.

"The *X*-ray Determination of Growth", special *X*-ray exhibit under the auspices of the Brush Foundation.

"Diagnosis and Treatment of the Commoner Skin Diseases", Dr. C. L. Cummer, Cleveland.

"Management of Peritonitis", Dr. R. S. Dinsmore, Cleveland.

"The Treatment of the Chronic Dyspeptic", Dr. V. C. Rowland, Cleveland.

"The Treatment of Cancer of the Breast", Dr. A. Strauss, Cleveland.

"Immunization in Childhood", Dr. J. A. Toomey, Cleveland.

"Agranulocytosis, Its Prevention and Treatment", Dr. Russell Haden, Cleveland.

Welcome to assembly, Dr. Lester Taylor, president of the Cleveland Academy of Medicine.

"Greetings from the Ohio State Medical Association", Dr. John A. Caldwell, Cincinnati, the President, and Charles S. Nelson, Columbus, executive secretary.

"Role of Allergy in General Medicine", Dr. Francis M. Rackemann, Boston, Massachusetts.

—OSMJ—

Medical Board Exams, June 4-7

Mid-summer examinations given by the State Medical Board will be held June 4, 5, 6 and 7, the board decided at its meeting in Columbus, April 2.

The written examinations will be held June 5 and 6 at the Gymnasium, Ohio State University, and the practical examinations, June 4 and 7 at St. Francis Hospital, Columbus.

Dr. Roy C. Hunter, Wapakoneta, recently appointed by Governor Davey as an eclectic member of the board, was present and qualified for his position on the board.

—OSMJ—

Academy of Physical Medicine will hold its annual meeting, June 12 and 13, at the Claridge Hotel, Atlantic City, New Jersey.

Physicians Are "Consumers," Not "Vendors," Under Sales Tax

There still seems to be some confusion in the minds of a few physicians as to whether physicians are classified as "consumers" or "vendors" under the state retail sales tax law.

The State Tax Commission has issued regulations classifying physicians as "consumers", thus relieving physicians of the responsibility and red tape of taking out vendors' licenses and becoming tax collectors.

Revised Sales Tax Ruling No. 7 of the Commission on this question reads as follows:

"A physician is the consumer of the various articles which he uses in connection with the rendition of his professional services and is required to pay the tax when purchasing such items. He is also required to pay the tax on all equipment, appliances, medicines, etc., when purchased by him, without regard as to whether the charge is in a lump sum, or is made up of items representing materials and services. The tax does not attach on the fee for professional services rendered by the physician, which include the utilization of various tangible articles as an incident to his professional practice where such tax has already been paid on these articles by the physician when purchased. If a physician is engaged in selling to the public medicinal supplies or other tangible personal property not in connection with his examination or professional service to a patient, he is a vendor, and must procure a vendor's license and collect the tax on all such sales."

Testimony of Physician As to Sanity of Patient Under Certain Conditions Not Privileged, Court Holds

The testimony of a physician as to a deceased patient's sanity, based solely upon his general observation of the patient, does not constitute a privileged communication within the meaning of Section 11494, General Code, according to a decision rendered by the Sixth District Court of Appeals in Heiselmann et al. v. Franks et al (48 Ohio App.)

The case was carried to the appellate court on error and involved the testimony of certain physicians in an action to sustain a will. It was claimed that Section 11494, General Code, prohibits the giving of evidence submitted by the physicians in this case.

The court in its opinion advanced the following argument:

"The evidence was introduced naturally in support of the will and the sanity of the testator. It seems to us obvious that this evidence does not constitute testimony by a physician concerning any 'communication made to him by his patient in that relation', nor, of course, is it 'advice to his patient.' Nor is it the exhibiting of the person or body of the patient, such as is construed to be within the purview of the section in the case of *Ausdenmoore et al., Exrs.*, v. *Holzback*, 89 Ohio St., 381, 106 N. E., 41, where it is stated at page 382:

" 'We hold that a communication by the patient to the physician may be not only by word of mouth but also by exhibiting the body or any part thereof to the physician for his opinion, examination or diagnosis, and that that sort of communication is quite as clearly within the statutes as a communication by word of mouth.'

"It is not such information as would be included in the rule laid down in *Collins* v. *Collins*, 110 Ohio St., 105, 143 N. E., 561, applying to attorney and client. It is evidence based solely upon the general observation of the patient, upon his acts and words, and these are of a nature which he would, as far as the record goes, have no possible reason for considering of a confidential character. The reason for the rule as to privileged communications is so clear that it seems difficult to see how by any stretch of the imagination the rule could be here applicable. Revelation of information concerning one's health, exhibition of the person or body, discovering the presence of disease are essentially confidential in character. The law provides for the protection of those revealing such facts. It justly assures those making such revelations that during their lives, and even after death, no one to whom such information becomes known, if acting in the relation of attorney or physician, will be permitted to reveal what has become known. They are therefore free to seek advice, help and comfort, and know that this confidence is secure. No such consideration certainly applies to one appearing before his physician in the most casual way. No patient would think of requiring that his physician be forbidden to say that judging from his general appearance and his conversation he was sane.

"What difference is there between what happens in such a situation in the office of the physician and his contact with the public generally? The only difference apparent is that from what he sees and hears the physician is better able to judge of the sanity of the patient."

—OSMJ—

The annual meeting of the American Association for the study of Goiter will be held in Salt Lake City, Utah, June 24, 25, and 26. Among those taking part in the program will be Dr. R. S. Dinsmore, Cleveland.

—OSMJ—

An indigent person suffering from a non-contagious disease who has a legal settlement within a township is entitled to hospitalization at the expense of the township trustees, if the same is necessary in any case where he is entitled to free medical attention, but there is no authority to transport such indigent and to pay his hospital expenses to a distant hospital if reasonable facilities for the particular type of care in question are available at a hospital less distant, according to a recent opinion handed down by Attorney General John W Bricker.

WORKMEN'S COMPENSATION

Digest of Recent Court Decisions and Excerpts of Interest to Physicians Pertaining to Industrial Commission Cases and Administrative Procedure.

IN the March issue of *The Journal* was published a detailed summary of the celebrated decision of the Ohio Supreme Court in the case of Industrial Commission of Ohio vs. Franken, in which the Supreme Court held that a claim to be compensable under the Workmen's Compensation Law must be based on evidence of some extraordinary or unusual happening at the time and place of the alleged disability.

Several recent Appellate Court decisions upholding the Industrial Commission in disallowing claims have been based largely on that decision and are herewith summarized because of the medical angles involved.

An employe engaged in handling cases of milk who, over a long period of time, develops an internal ailment resulting from repeated contacts of the cases with his body, does not suffer an "injury" within the meaning of the Workmen's Compensation Law, the Court of Appeals of Lucas County held in *Industrial Commission of Ohio vs. Borchert*, 49 Ohio App.

In the case of *Industrial Commission of Ohio vs. Auler*, 49 Ohio App., the same court held that impairment of vision caused by a hemorrhage of the retina, attributable to the doing of heavy work day after day, is not an "injury" such as is contemplated by the Workmen's Compensation Law.

A recent case involving a back injury indicates when the Franken decision is not applicable. In this, *Cavanaugh vs. Industrial Commission of Ohio*, 48 Ohio App., the Court of Appeals of Cuyahoga County held that where a workman, while employed by a warehouse company as a laborer, and in the course of his employment in loading freight, attempted to catch a heavy sack which had slipped from his hands, and sustained an injury to his back as a result thereof, such injury was "accidental" within the meaning of the Workmen's Compensation Act.

An employe of a Cleveland company slipped and fell while getting off a truck and sustained a hernia. The claim for injury was recognized and compensation paid. The injury was sustained September 22, 1933, and on February 14, 1934, the claimant died and the widow applied for a death award. The medical department, reporting on the case, was of the opinion that the brain abcess which was the direct cause of death, followed a case of postoperative pneumonia and that a direct relationship can be traced between the original injury and the cause of death. The employer contended claimant made a normal recovery from the original injury and that his death could not be ascribed to it. The Commission held that the death of decedent was due to an injury sustained in the course of his employment and *granted the death award.*

* * *

A life guard in the employ of a Canton swimming pool, was standing on a wooden tower under a steel-shafter umbrella, warning bathers to vacate the swimming pool during a storm, when he was struck by lightning and killed. His father applied for an award for funeral expenses. While death from lightning is looked upon as "an act of God" and is ordinarily held non-compensable, the claims reviewer was of the opinion that the steel shaft of the umbrella under which decedent was standing may have attracted the lightning and constituted an unusual hazard of the decedent's occupation and that the "hazards of the employment were made active by the forces of nature." *The Commission concurred in this view and made the award for funeral expenses, there being no dependency.*

—OSMJ—

Fremont—Dr. C. I. Kuntz addressed the students of Tiffin Business University recently.

Cincinnati—Dr. Martin Fischer, University of Cincinnati Medical College, spoke on "Permanent Pigments", at the Art Academy.

Salem—Dr. Gail A. Roose addressed members of the Salem Rotary Club.

Toledo—Dr. R. C. King, chief of obstetrics and gynecology at St. Vincent's hospital, was elected councilor of the American College of Surgeons at the district meeting held in Cleveland, April 4.

Cincinnati—Dr. E. E. Bishop, superintendent of Hamilton County Tuberculosis hospital, gave a series of three radio talks on prevention of tuberculosis.

Marion—Dr. John A. Dodd, president of the Marion Academy of Medicine, was guest speaker at the third of a series of meetings on maternal welfare, sponsored by the Epsilon Circle, Child Conservation League.

Cincinnati—Dr. Karl G. Zwick and Dr. Samuel L. Bauer spoke at a recent meeting of the Cabell County Medical Society, Huntington, West Virginia.

Toledo—The Toledo Medical Study Club was addressed recently by Dr. T. C. Kiess on the subject of "Tubal Insufflation".

NEWS NOTES of OHIO

Cleveland—Dr. T. Wingate Todd, professor of anatomy, School of Medicine, Western Reserve University, spoke before the Thomas Hinman mid-winter clinic at Atlanta, Georgia, March 18, on "Physical Constitution of the Growing Child". He also addressed President Hope's group at the University of Georgia on "Negro Child Development".

Cincinnati—Dr. Alfred Friedlander, dean of the College of Medicine, University of Cincinnati, addressed school physical directors at the University Y. M. C. A. His topic was "The Health of the School Child".

Zanesville—Dr. George T. Harding, Columbus, was guest speaker at a luncheon meeting of the Rotary Club. He spoke on "Nervous People".

Bucyrus—Dr. R. J. Caton, who was injured some time ago in an automobile collision, resumed his practice early in April.

Marion—Dr. N. Sifrit, Marion County health commissioner, spoke on "Prevention of Communicable Diseases", at a district meeting of the Ohio Nurses Association, at the City Hospital, Marion.

Cincinnati—Dr. Emmett Fayen spoke on "Social Security" at a meeting of the Men's Club at the Unitarian church.

Columbus—Dr. J. F. Baldwin addressed the Rationalist Society recently on "Progress of Medicine".

Burton—Dr. W. A. Reed, formerly of Cleveland, has opened offices in this city.

Cincinnati—Dr. Kennon Dunham, president of the National Tuberculosis Association and medical director of the Hamilton County Tuberculosis Sanatorium, addressed a luncheon meeting of the Engineers' Club of Dayton recently.

McArthur—Dr. E. T. Dando, of Wellston, who recently returned from post graduate work in New York, will open offices formerly occupied by the late Dr. H. S. James. Dr. Franklin Wills, Columbus, will become associated with him following completion of his internship at White Cross Hospital, July 1.

Toledo—Dr. L. A. Levison, representing the education bureau of the Toledo Academy of Medicine, gave a radio address on "Nerves and your Digestion".

Wilmington—Dr. Kelley Hale addressed Wilmington High School pupils recently on "Self Education".

Marion—Dr. C. G. Smith gave a talk on "Natal Care" at the city library, under the auspices of Epsilon Circle of the Child Conservation League.

Lima—Dr. F. G. Maurer was guest speaker at a meeting of the Kiwanis Club of Ottawa, recently.

Bellefontaine—Dr. C. K. Startzman has been retained as physician for the Logan County Home.

Toledo—Dr. Bernard Steinberg spoke at a meeting of Kappa Phi Sigma, University of Toledo, on "The Future of Medicine from Its Past".

Springfield—Dr. H. A. McKnight recently gave an illustrated lecture on "Surgical Anatomy and Spinal Injections", at Wittenberg College, under the auspices of the Royal Scientific Society.

Youngstown—Dr. William M. Skipp addressed Junior Clio Club members on "Medical Care in the Home".

Cleveland—Dr. James Dickson spoke before members of the Kiwanis Club, Lorain, recently on "Child Welfare". His talk was illustrated with moving pictures.

Cincinnati—Dr. D. J. Bradley addressed members of the Mother of Mercy Mothers' Club and their friends at a recent meeting.

Dayton—Dr. Walter M. Simpson addressed members of the Fort Wayne (Indiana) Medical Society recently.

Bowling Green—Dr. O. S. Canright is recovering from injuries received in an automobile collision.

Wooster—Dr. Eva Cutright addressed members and guests of the Ashland Mothers' Club at a recent meeting.

Steubenville—Dr. A. E. Weinstein was guest speaker at the regular meeting of the Marshall County (West Virginia) Medical Society. His subject, "Diagnosis and Treatment of Cancer of the Rectum", was illustrated with lantern slides.

Massillon—Dr. A. G. Hyde, superintendent of the Massillon State Hospital, spoke at a recent meeting of the American Legion.

Cincinnati—Dr. Floyd P. Allen spoke before a luncheon meeting of the Woman's City Club, recently.

Marion—Dr. A. Rhu, Marion's oldest practicing physician, celebrated his eighty-sixth birthday anniversary by attending the convention of the American College of Surgeons, held recently in Cleveland.

Fairport—Dr. E. L. Haffner has been reappointed county physician of Lake County.

Gallipolis—Dr. Charles E. Holzer recently purchased the first airplane ambulance to be used in southern Ohio.

Nelsonville—Dr. A. L. Pritchard has been named city relief physician.



Oliver G. Chance, M.D., Cincinnati; University of Cincinnati College of Medicine, 1924; aged 35; member of the Ohio State Medical Association and Fellow of the American Medical Association; died April 8 from spinal meningitis. Dr. Chance had practiced in Cincinnati since completing his internship in General Hospital, Cincinnati. Surviving him are his widow, his parents, and an uncle, Dr. Willis B. Gatch, dean of Indiana State Medical College, Indianapolis.

Robert C. Droege, M.D., Cleveland; Western Reserve University School of Medicine, 1897; aged 61; member of the Ohio State Medical Association and the American Medical Association; died March 19. He had practiced in Cleveland since his graduation, and was coroner for Cuyahoga County for three terms.

John E. Furry, M.D., Springfield; Medical College of Ohio, Cincinnati, 1899; aged 66; died March 13, following a long illness. He practiced for six years at Washington C. H. before locating in Springfield, where he practiced for nearly 30 years. Dr. Furry was elected to the Springfield city commission in 1921, and served as mayor from January, 1922 to January, 1924. He was a member of the Methodist Episcopal Church, and the Springfield Lodge of Elks. Surviving him are his widow, one son, and one daughter.

George W. Martin, M.D., Portsmouth; Eclectic Medical College, Cincinnati, 1908; aged 52; member of the Ohio State Medical Association and the American Medical Association; died April 2 of pneumonia, which followed a cerebral hemorrhage. Dr. Martin had practiced in Portsmouth for many years, and was a member of the staff of the Portsmouth General Hospital. He is survived by his widow, two daughters, his mother, two sisters, and four brothers, Dr. H. B. Martin of Huntington, W. Virginia; Dr. I. N. Martin, of Portsmouth; Dr. H. P. Martin, of Newark, Ohio, and Dr. A. B. Martin, of Blanchester.

R. M. Manley, M.D., Cleveland; Western Reserve University School of Medicine, 1904; aged 59; former member of the Ohio State Medical Association; died March 21 from a heart attack. Dr. Manley began practice in Ravenna, and in 1908 located in Cleveland. He was a veteran of the World War, and a member of the American Academy of Science, the Acacia Country Club, a Mason, a Knight Templar and a Shriner. His widow survives him.

George Howard Mayhugh, M.D., Westerville; Ohio Medical University, Columbus, 1895; aged 78; former member of the Ohio State Medical Association; died April 8, following a long illness. He had practiced in Westerville since 1886, and was formerly a member of the board of education, the board of public affairs, and the city council. He is survived by five nieces.

Charles P. McKee, M.D., St. Marys; Starling Medical College, Columbus, 1905; aged 55; member of the Ohio State Medical Association and Fellow of the American Medical Association; died March 29 of pneumonia. Dr. McKee had practiced in St. Marys for thirty years. He was a former member of the municipal school board, and active in local civic organizations. He was a member of the Presbyterian Church and the Masonic lodge. Surviving him are his widow, one son, two brothers and one sister.

Edwin S. Russell, M.D., Alliance; Western Reserve University School of Medicine, Cleveland, 1873; aged 86; died March 28, following a long illness. Dr. Russell practiced in Tuscarawas County for 25 years before locating in Alliance. He retired from active practice in 1919. His widow and three daughters survive him.

John C. Schutzbach, M.D., Strasburg; Columbus Medical College, 1891; aged 66; member of the Ohio State Medical Association and Fellow of the American Medical Association; died March 14 of coronary embolism. Dr. Schutzbach had practiced at Strasburg for 44 years. He was a member of the Lutheran Church and a Mason. Surviving are his widow and three daughters.

William W. Shriner, M.D., Cincinnati; licensed 1896; aged 89; graduated from Miami University, Oxford in 1865, and from the Eclectic Medical College, Cincinnati about 1870. He practiced for thirty years at Liberty, Indiana, and for 34 years in Cincinnati. Dr. Shriner was the third of five generations of physicians. He was a member of the Lodge of Masons and the Scottish Rite. Surviving him are his widow, two sons and a daughter.

Harry W. Sims, M.D., Columbus; Rush Medical College, University of Chicago, 1908; aged 53; died March 29 of heart disease. Dr. Sims practiced in Cambridge until 1915 when he located in Columbus. He is survived by his widow and one brother.

Leon S. Talaska, M.D., Toledo; Toledo Medical College, 1898; aged 60; former member of the Ohio State Medical Association and the American Medical Association; died March 11 of pneumonia. He had practiced in Toledo for 37 years.

Surviving him are his widow, one son and two daughters.

J. W. Weber, M.D., Lewisville; Starling Medical College, Columbus, 1882; aged 75; former member of the Ohio State Medical Association; died March 9 from injuries received in a fall. Dr. Weber had practiced in Monroe county for 50 years and for several years served as county health commissioner. He was a member of the Lutheran Church and a Mason. Besides his widow, he is survived by one son and one daughter.

—OSMJ—

California State Medical Society Endorses Sickness Insurance

Following the session of the House of Delegates of the American Medical Association in Chicago in February, a meeting of the house of delegates of the California Medical Association was held in Los Angeles on March 2. A special committee of five, appointed by the house of delegates of the California Medical Association in 1934, submitted a report of a survey of health care in California and a plan for the administration of health insurance. This committee, with an advisory council, had made the survey, which involved a study of medical practice as conducted by physicians, dentists, osteopaths, hospitals and clinics, and a direct study of the health care of the public obtained through 48,000 questionnaires secured from families by field workers and by mail. The cost of the survey was approximately $80,000, of which some $25,000 was supplied by the California Medical Association and the remainder through an appropriation by the government.

The committee of five rendered a majority report signed by four members to the effect that health service be furnished on a voluntary basis. In accordance with the instructions of the California house of delegates given in 1934, the committee prepared a health insurance bill but recommended that it be not adopted. At the same time Dr. Alson R. Kilgore presented a resolution that the California Medical Association establish an organization for the specific purpose of providing means whereby the cost of care of sickness and injury for those of moderate and low incomes may be met by the method of periodic payments in advance, that this organization provide for meeting costs of professional service and hospital care, and that the council of the society perfect a plan of organization for these purposes. Subsequent provisions requested the inclusion in such plans of the free choice of physician, dentist and hospital, and maintenance as far as possible of the traditional patient-physician relationship. It was also requested that the plan be developed so as to operate without profit to any one. After considerable debate, both these reports were referred to a reference committee.

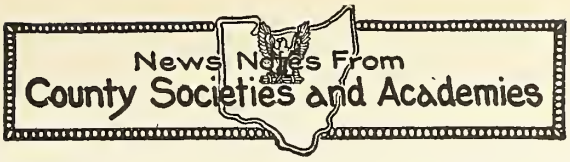
Following this statement, Dr. Rodney A. Yoell presented a minority report recommending that the house of delegates of the California Medical Association endorse the principle of compulsory health insurance, submitting with this recommendation a bill in support of the plan with the idea that this bill be the basis of discussion of the California Medical Association with the senate interim committee of the California legislature. This also was referred to the reference committee.

The council of the California Medical Association submitted to the house of delegates six questions as to the point of view of that body in relationship to medical practice in California and also presented some resolutions, which were referred to a special reference committee. These resolutions concerned the relationship of the medical association to the county hospital, the corporate practice of medicine and compensation for medical service rendered to those on relief. After extended discussion the house of delegates approved submission to the legislature of a bill providing for both compulsory and voluntary sickness insurance, leaving it to the council and legislative committee of the association to work out the proper measures with the legislature.

In considering these actions of the house of delegates of the California Medical Association, it should be realized that there are already before the California state legislature bills legalizing the practice of medicine for profit by corporations and bills providing care in county hospitals in that state to all who apply for admittance regardless of their ability to pay, and that the federal and the state emergency relief administration in that state have been unable to work out a satisfactory plan of medical care for those on relief with organized medicine and the allied professional groups. This state of affairs may have been significant in the action finally taken. However, California seems to have been tending toward a compulsory sickness insurance system. Much depends on whether or not the medical profession after its conference with representatives of the legislature will be able to develop some system that will be satisfactory to all concerned.

The proposed legislation submitted by Dr. Rodney Yoell in connection with his individual minority report seems to follow closely the Epstein scheme of health insurance, with the exception that the proposed bill provides for control under a director who must be a physician and a health insurance commission of five, of which two members must be physicians.

The action taken does not indicate, moreover, that the majority of the house of delegates of the California Medical Association favors a system of sickness insurance including both the compulsory and voluntary forms.—*Jour. A. M. A.*, April 6, 1935.



First District

ACADEMY OF MEDICINE OF CINCINNATI

(H. J. Lavender, M.D., Secretary)

Meetings of the Academy held during April were as follows:

April 1—General Session. Program: "The Experimental Production and Medical Management of Renal Calculi", by Dr. C. C. Higgins, of Cleveland. The paper dealt with clinical observations inferring a definite relationship between calculus formation and deficiency in the diet. Experimental evidence has shown that urinary calculi may be produced in animals maintained on a diet deficient in Vitamin A, and with restoration of Vitamin A to the diet the calculi undergo spontaneous dissolution.

April 8—Case Reports: "Eczema Vaccination in one-year-old Infant" (lantern slides), by Dr. D. J. Bradley. 'Mild Cardio Fibrosis in Progressive Muscular Dystrophy", by Dr. Sander Cohen. "Three Cases of Carcinoma of the Face", by Dr. Daniel J. Kindel. "A Case of Osteoporosis of the Foot Following Injury to the Knee", by Dr. Josiah Smith. "Streptococcic Meningitis Treated by Intra-Spinal Air Injections—with Recovery", by Dr. Mendel Zeligs.

April 15—General Session. "Non-Tropical Sprue, with Report of a Case", by Dr. Clark S. Fitzmorris, with discussion by Dr. S. D. Simon and Dr. D. V. Remsen. "The Clinico-Pathologic Significance of Cancer Grading", by Justin J. Stein, with discussion by Dr. M. M. Zinninger and Dr. Irving H. Schroth.

April 22—General Session. "A Recent Local Epidemic of Food Poisoning", by Dr. Nathan Abrams, with discussion by Dr. Robert C. Rothenberg. "The Diagnosis of Lead Poisoning in the Light of Recent Information", by Dr. Robert A. Kehoe.

April 29—General Session. "Procedures and Results in Gastro-duodenal Ulcer", by Dr. Bernhard Newburger, with discussion by Dr. Henry W. Bettman and Dr. Louis J. Ransohoff. "Chemical Aspects of Arteriosclerosis", by Dr. R. S. Austin and Dr. Pearl M. Zeek, with discussion by Dr. Alfred Friedlander.

Clinton County Medical Society held its regular monthly meeting on Tuesday, March 5. Dr. Frank Stevenson, of the General Hospital, Cincinnati, spoke on "Scarlet Fever".—News Clipping.

Warren County Medical Society met for its regular monthly meeting on Tuesday, April 2, at Harmon Hall. Dr. John Skavlem, of Cincinnati, spoke on "Diagnosis of Chest Conditions in General, including Chronic Tuberculosis and Bronchial Infections".—News Clipping.

Second District

Champaign County Medical Society held a luncheon meeting Thursday, March 11, at the Douglas Hotel, Urbana. The regular business session preceded a talk by Dr. Starling C. Yinger, of Sidney.—News Clipping.

Darke County Medical Society held its regular monthly meeting on Friday evening, March 15, at the Christian Church in Greenville. Following a dinner at 6:30 p. m., Dr. R. W. Kissane, of Columbus, addressed the society on the subject of "Traumatic Heart Disease".—News Clipping.

Greene County Medical Society met Thursday, April 4, in Xenia for its regular meeting. The extensive epidemic of scarlet fever was discussed as to difficulties of diagnosis, and the members agreed with Health Commissioners, Drs. DeHaven and Marshall, that doubtful cases should be reported as scarlet fever. Brief three-minute talks on recent advances in medicine were made by Drs. Best, Madden, Harold Messenger, Shields, Sontag, and Ungard, covering different specialties. Dr. L. E. Valker, of Cincinnati, reported a case of Kaposi's tumor (multiple hemorrhagic sarcoma of skin) and discussed the differential of dermatological sarcoma. At the business session, Dr. Ernest Ekermeyer of Xenia, was accepted as a new member.—R. R. McClellan, M.D., Secretary.

Miami County Medical Society held its April meeting at Piqua Memorial Hospital on Friday afternoon, April 5. Program included a paper on "Post-Operative Care of Surgical Patients", by Dr. K. F. Lowry, of Troy. Discussion was opened by Dr. G. R. Upton, of Piqua.

Montgomery County Medical Society held its regular meeting on Friday evening, April 5, in the auditorium of the Fidelity Building, Dayton. Dr. A. T. Bowers presented a paper on "Acute Abdominal Conditions", with discussion opened by Dr. H. R. Huston. "Parietal Pain in Abdominal Diagnosis", was presented in a paper by Dr. R. C. Austin, with discusison opened by Dr. A. W. Carley.

A dinner meeting on Friday evening, April 19, was held at the Miami Valley Hospital, with Dr. J. O. Arnold, Temple University, Philadelphia, as guest speaker. His subject was "Dehydration

Treatment of Eclampsia". On the afternoon of the same day, Dr. Arnold addressed nurses at St. Elizabeth's Hosiptal, on "New Pre-Natal Care". This program was under the auspices of the Obstetrical Group of the Society.—Bulletin.

Preble County Medical Society held its regular meeting at Seven Mile Tavern, Eaton, on Thursday evening, March 21. Following a seven o'clock dinner, the following program was presented: "Acute Conditions of Abdomen", by Dr. A. T. Bowers, of Dayton.—Bulletin.

Third District

Auglaize County Medical Society held its regular meeting at the City Hall, St. Marys, Thursday evening, April 11th, with an audience of twenty-five. Drs. Fergus and E. H. Hedges of Lima, and Drs. F. E. Ayers, D. H. Richardson and R. E. Riley of Celina, were visitors.

Dr. C. A. Coleman of Dayton, O., addressed the meeting on "Recent Developments in the Diagnosis and Treatment of Kidney Diseases", emphasizing that the various forms of Nephritis are really systemic conditions and that they should be treated accordingly.

Resolutions of appreciatiton and respect in consideration of the death of Dr. Charles P. McKee, of St. Marys, which occurred on March 29, were unanimously adopted.

The congratulatory announcement was made of the appointment by Governor Davey of Dr. R. C. Hunter, Wapakoneta, to be a member of the State Medical Board.—Chas. C. Berlin, M.D., Secretary.

Hancock County Medical Society held a joint meeting with dentists of the county, on Thursday evening, March 7, at the Elks Club, Findlay. U. Garfield Rickert, D.D.S., of the University of Michigan Dental School, Ann Arbor, gave a very interesting talk on "The Relation of Dental Infection to Arthritis". Fifty physicians and dentists from Findlay and Hancock County attended, as well as visitors from Lima, Carey, Bluffton and Forest.—R. S. Rilling, M.D., Secretary.

Hardin County Medical Society entertained 55 members and guests with a dinner, Wednesday evening, March 13, at the Kenton Cafe. Physicians were present from adjoining counties and Columbus, and guests included public health nurses, and business and professional men of the community. Dr. E. G. Horton, of Columbus, spoke on "Immunizations".—News Clipping.

Marion County Academy of Medicine, met Tuesday night, April 1, at the Marion City Hospital for its regular monthly meeting. Dr. Stanley S. Sidenberg, of Cleveland, addressed the society on "Tuberculosis, Conception of and Treatment by Pneumothorax". His talk was illustrated with lantern slides.—News Clipping.

Seneca County Medical Society held its regular monthly meeting at the Shawhan Hotel, Tiffin, on Thursday evening, March 21. Dr. W. J. Gardner, Cleveland, discussed various nerve disorders which are now treated by surgical methods. A dinner preceded the meeting.—News Clipping.

Fourth District

TOLEDO ACADEMY OF MEDICINE

(F. C. Clifford, M.D., Secretary)

Programs for meetings of the Academy held during March and April, were as follows:

March 1—General Meeting. "Proposals and Developments toward Sickness Insurance", by Dr. R. G. Leland, Chicago, director, Bureau of Medical Economics, American Medical Association.

March 8—Joint meeting of the Toledo section of the American Chemical Society and the Section of Pathology, Experimental Medicine and Bacteriology. "Lead Absorption and Lead Poisoning", by Dr. Robert A. Kehoe, associate professor of physiology, University of Cincinnati College of Medicine.

March 15—Medical Section. "The Physician's Responsibility in the Sex Hygiene Problem", by Dr. Paul Hohly. "The Average Citizen and the Social Hygiene Problem", by Rev. Harlan M. Frost, secretary, Toledo Council of Churches. Discussants: Mr. Ralph E. Dugdale, secretary, Toledo Council of Churches, Rev. Francis J. MacElwane, superintendent of Catholic Schools, and Dr. M. D. Haag.

March 22—Surgical Section. "The Diagnosis and Treatment of Nonsuppurative Osteomyelitis", with Lantern Slide Demonstration, by Dr. John T. Murphy. Discussion opened by local pathologists.

April 5—General Meeting. "The Plan of Reorganization of the Industrial Commission", by A. D. Caddell, secretary and J. W. Beall, member of the Industrial Commission of Ohio. Discussion by Dr. R. J. Secrest, Medical Department; C. C. Core, Director of Legal Department; Clarence Buckenmyer, Manager, Toledo Office and George L. Meehan, Division of Safety and Hygiene, of the Commission; General discussion and suggestions from members of the Academy.

April 15—Section of Pathology, Experimental Medicine and Bacteriology. "Clinical-Pathological Conference on Cancer of the Lung", conducted by Drs. T. L. Ramsey and J. T. Murphy. Cases were presented by Drs. A. A. Applebaum, E. J. McCormick, H. W. H. Nelles, R. A. Diethelm, and F. C. Clifford.

April 22—Medical Section. Symposium on "Recently Developed Mechanical Aids to Diagnosis: 1. "A. C. H. Index—A New Method of Evaluating the Nutrition Status of Children", by Dr. N. C. Spencer. Discussion by Dr. S. D. Giffen. 2. "The Impedance-Angle Test for Goitre", by Dr.

N. W. Gillette; Discussion by Dr. W. H. Rheinfrank. 3. Demonstration of a Portable Vision-Testing Apparatus, by Dr. I. B. Winger. Discussion by Dr. A. L. Steinfeld.—Bulletin.

Ottawa County Medical Society met at the home of the president, Dr. L. L. Belt, at Marblehead, on Thursday evening, March 14. Following a dinner and business session, Dr. J. P. Tucker, of Cleveland, gave an interesting illustrated talk.

Sandusky County Medical Society held its regular meeting in the Council Chamber, Fremont, on Thursday evening, March 28. Dr. Karl D. Figley, of Toledo, spoke on "The Management of Asthmatic Cases", and Dr. Evan A. Galbraith, also of Toledo, discussed the surgical treatment of asthma. A feature of the meeting was a demonstration given by pupils of the hard of hearing classes at the Hayes school, in charge of Misses Ruth Paxson and Edna Spencer, teachers at the school.—News Clipping.

Wood County Medical Society met at the Woman's Club, Bowling Green, on Thursday evening, March 21. Following a dinner and short business session, Dr. H. J. Powell, Bowling Green, spoke on "The Physician—His Future Outlook". Discussion was opened by Dr. Barney J. Hein, Toledo, Councilor of the Fourth District. Thirty-one physicians were present, including 11 visiting physicians from adjoining counties.—Bulletin.

Fifth District

ACADEMY OF MEDICINE OF CLEVELAND

(Justin A. Garvin, M.D., Secretary)

Programs for meetings held during April, were as follows:

April 10—Practice of Medicine Section. "Evilpal Soluble, a new Intravenous Anaesthetic", Dr. Stanley Gardner. "Clinical Diagnosis of Periarteritis Nodosa", Dr. Milton Cohen. "Electrocardiographic Diagnosis of Coronary Artery Disease", Drs. Leonard G. Steuer, and M. Siegel.

April 12—Clinical and Pathological Section. "A Case of Pyothorax and Pyopericardium", Dr. J. W. Epstein. "The Effects of Chronic Sinus Infections in Young Children; Case Presentations", Dr. M. Metzenbaum. "A Case of Dextrocardia with Aortic Insufficiency", Dr. M. L. Siegel. "A Case of Hyperactivity of the Posterior Portion of the Pituitary Gland with Hyperthyroidism", Drs. G. M. Churukian and E. H. Adler. "A Case of Chylothorax Due to a Bullet Wound", Dr. A. Strauss. "A Retroperitoneal Cyst Arising in a Persistent Metanephros with Congenital Absence of the Right Kidney and Ureter", Drs. L. W. Krauss and R. Strauss. "The Gaenslen Treatment of Osteomyelitis of the Heel", Dr. L. E. Papurt. "A Cerebello-Pontine Angle Tumor with Operation and Recovery", Dr. M. D. Friedman. "A Fracture Dislocation Through the Sacro-Illiac

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April 26—Ophthalmological and Oto-Laryngological Section. Symposium on Headache: (a) From the Viewpoint of the Ophthalmologist, Dr. O. F. Simonds; (b) From the Viewpoint of the Oto-laryngologist, Dr. James Collins; (c) From the Viewpoint of the Internist, Dr. Richard Dexter; (d) From the Viewpoint of the Neurologist, Dr. Louis Karnosh.—Bulletin.

Ashtabula County Medical Society met Thursday evening, March 12, for a dinner at the Hotel Cleveland, Conneaut. The program included an interesting talk by Dr. Wm. M. Skipp, Youngstown, secretary of the Mahoning County Medical Society, and an address by Dr. Perkins, research director of the Parke Davis laboratories.—News Clipping.

Erie County Medical Society met Thursday evening, March 28, at Hotel Rieger, Sandusky. Possible changes in the medical relief system were discussed.—News Clipping.

Lake County Medical Society held its regular monthly meeting on Tuesday, March 26, in Painesville. Following the business session, two motion pictures, supplied by the Davis and Geck Company, on surgical procedures, were shown.—Mabel L. Pearce, M.D., Secretary.

Lorain County Medical Society met Tuesday, March 12, at Hotel Lorain, for its regular meeting. A five o'clock dinner was served to fifty members of the society. General business was transacted before the address by Dr. William D. Fullerton, of Cleveland. His subject, "Carcinoma of the Uterus; Its Early Diagnosis and Treatment", was most instructive and was received with intense interest.

Dr. Louis Karnosh, head of the Psychopathic department of Cleveland City Hospital, delivered a most entertaining address on "The History of Neuro-Psychiatry" at the meeting of the Lorain County Medical Society held Tuesday evening, April 9, at Elyria Memorial Hospital. At five-thirty o'clock, 52 members of the society were served dinner in the hospital dining room.

Dr. L. H. Trufant, of Oberlin, president of the society, conducted the meeting at which time Dr. Gunn, of Oberlin, presented his new form of intravenous injection which was referred to a committee from the society for investigation. This committee will report on their findings at the September meeting.—Z. Pitcher, M.D., Secretary.

Medina County Medical Society met at the Rebecca Hall in Lodi on Thursday afternoon, March 28. Dr. F. C. Potter, of Akron, gave an address on "Laboratory Methods in General Practice". Wives of members were guests during the afternoon at a bridge party given by Mrs. E. L. Crum. The meeting was concluded with a dinner at the Rebecca Hall.—J. K. Durling, M.D., Secretary.

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Sixth District

Union Medical Association of the Sixth Councilor District met at the Elks Club, Canton, on Wednesday, April 10. Visiting doctors attended a meeting of the Stark County Medical Society held in the evening. The program for the afternoon included a business session, and the following papers: "Acute Conditions of the Middle Ear", Dr. J. R. Dowling, of Massillon, and Dr. J. E. Springer of Akron. "Acute Conditions of the Nose and Accessory Sinuses", Dr. George L. King, of Alliance, and Dr. William Evans of Youngstown. "Acute Conditions of the Throat", Dr. J. N. Hoffman, of Canton, and Dr. E. W. Douglass, of Wooster. An address was given by Rabbi Charles Latz, of Canton, following the dinner. Officers of the Association are: Dr. R. S. Friedley, Akron, president; Dr. K. H. Harrington, Akron, secretary; Dr. Harry S. Davidson, of Akron, Councilor for the District.—News Clipping.

Portage County Medical Society met Thursday evening, April 4, at the office of Dr. W. B. Andrews, in Kent. Dr. D. Roy McCullagh, of Cleveland, spoke on "The Etiology and Treatment of Benign Prostatic Hypertrophy in Man". Dr. G. J. Waggoner, of Ravenna discussed present status of new and proposed laws.—Bulletin.

Richland County Medical Society held its regular meeting at the General Hospital, Mansfield, on Thursday afternoon, March 28. Dr. Louis Karnosh, of Cleveland, gave an interesting address on "Psychiatry in Medicine".

More than 40 physicians were present for the April meeting of the Society, held at the General Hospital, Mansfield, Tuesday, April 2. The guest speaker was Dr. Winchell Craig, of the Mayo Clinic, Rochester, Minnesota.—News Clipping.

Stark County Medical Society met Tuesday evening, March 19, in Canton. Dr. William D. Fullerton, of Cleveland, in his talk on "Cancer", outlined the latest developments in combating the disease with radium, surgery and *X*-ray. His address was followed by lantern slides and a motion picture showing radium treatment of cancer.

Members of the Union District Medical Society attended the meeting of the Stark County Medical Society in Canton on Wednesday evening, April 10. Dr. John M. Scott of Canton, and Dr. L. L. Bottsford, of Akron, discussed "Bleeding During Pregnancy"; Dr. V. B. Antes and Dr. L. E. Leavenworth of Canton, reviewed recent publications on eclampsia, and Dr. R. K. Ramsayer, of Canton, presented motion pictures on obstetrics.—News Clipping.

Summit County Medical Society met at the Mayflower Hotel, Akron, on Tuesday evening, April 2, for its regular meeting. A symposium on Anaesthesia was presented, as follows: 1. "Ni-

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Seventh District

Belmont County Medical Society met Thursday evening, March 7, at the Board of Trade rooms, in Martins Ferry. The meeting was devoted to a business session, and a general discussion of "Social Insurance As It Applies to Medicine".—News Clipping.

Columbiana County Medical Society held a well attended meeting on Tuesday evening, March 12, at Lisbon. Guests included nurses from Salem. The society was addressed by Drs. C. W. Elkin, A. B. Miller, Thomas H. Manley, Jr., and William Shapera, members of the staff of the Allegheny General Hospital, of Pittsburgh, Pennsylvania, on the subject of "Vertigo."—Guy E. Byers, M.D., Secretary.

Coshocton County Medical Society met at the City Hospital, Coshocton, on Thursday evening, March 28. Speakers included Drs. R. E. Hopkins, and W. H. Keenan, of Coshocton.—News Clipping.

Jefferson County Medical Society held its regular meeting on Tuesday evening, March 19, at Ohio Valley Hospital in Steubenville. Dr. Joseph H. Barach, associate professor of medicine, medical director of the Falk Clinic, University of Pittsburgh, addressed the meeting on "The Modern Treatment of Diabetes". Members of the Brooke County Medical Society and the Hancock County Medical Society of West Virginia were present.—John Y. Bevan, M.D., Secretary.

Tuscarawas County Medical Society met Thursday evening, March 14, in the New Philadelphia Council Chamber. "Some Observations After Forty-Five Years of Practice of Medicine" was the subject of a talk by Dr. J. A. McCollam of Uhrichsville. Dr. W. R. Stager, of Dover, told of his observations from an obstetrical viewpoint, following a recent visit to their hospital. Films showing obstetrical work at a Chicago maternity hospital were shown.—News Clipping.

Eighth District

Athens County Medical Society met at the First Methodist Church, Nelsonville, on Monday, April 1. Dr. William P. Smith, of Columbus, spoke on the subject, "The Breast". This was followed by an illustrated lecture on the same subject by Dr. R. S. Fidler, also of Columbus.—News Clipping.

Guernsey County Medical Society met Thursday evening, March 21, at the Colonial Inn, in Old Washington, with wives of members as

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guests. At 6:30 a banquet was served, and the evening was spent in an informal program, which was thoroughly enjoyed by all present.

Regular bi-monthly meeting of the Society was held at the Berwick Hotel, Cambridge, on Thursday, April 4. Luncheon was followed by a general discussion on "Early Diagnosis and Treatment of Tuberculosis".—O. Reed Jones, M.D., Correspondent.

Muskingum County Academy of Medicine held its regular meeting on Wednesday evening, April 3, in the University Club rooms, Zanesville. Dr. D. G. Caudy, of Zanesville, presented a paper on "The Important Advances in Medicine during 1934".—Bulletin.

Perry County Medical Society met Monday noon, March 18, at the Park Hotel, New Lexington, for a dinner meeting. The principal speaker was Dr. F. J. Crosbie, county health commissioner, who discussed "Change in Type of Contagious Disease".—News Clipping.

The April meeting of the Society was held at the Park Hotel, New Lexington, on Monday, April 15, at the noon hour. Dr. Wm. Morrison, of Columbus spoke on "Lesions of Gastro-Intestinal Tract".—F. J. Crosbie, M.D., Secretary.

Ninth District

Scioto County—The regular meeting of the Hempstead Academy of Medicine was held at recreational hall, Nurses Home, Portsmouth, on Monday evening, April 8. Dr. G. F. McKim, professor of urology, University of Cincinnati, College of Medicine, addressed the society on "Differential Diagnosis of Prostatic Conditions". Following the meeting, members were entertained at the home of Dr. Frank C. Beeks.—Bulletin.

Tenth District

COLUMBUS ACADEMY OF MEDICINE

(Drew L. Davies, M.D., Secretary)

April meetings of the Academy included the following programs:

April 1—"The Treatment of Asthma", Dr. Milton B. Cohen, of Cleveland.

April 8—Symposium on Genito-Urinary Diseases; "Ureteral Calculi", Dr. F. C. Haney; "Transurethral Resection of the Prostate Gland" (lantern slides), Dr. Frank W. Harrah; "Renal Tuberculosis", Dr. Hugh A. Baldwin; "Nephrectomy—Evaluation of Results", Dr. W. N. Taylor. Discussions by Dr. H. O. Bratton and Dr. L. J. Roth.

April 15—Combined meeting of the Academy with the Columbus Dental Society. "Studies Among Primitive Races for Light on Why Modern Civilization Hastens General Physical and Dental Degeneration", Weston A. Price, D.D.S., M.S., Cleveland.

April 22—General Practitioners' Section. "Heart Disease in Pregnancy", Dr. Thomas A.

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Vogel. "Old and New Analgesics in Obstetrics", Dr. Ralph E. Ramey. Discussions by Dr. G. B. Nessley and Dr. J. A. McClure.—Bulletin.

Crawford County Medical Society met Monday evening, April 1, at Bucyrus City Hosiptal. An address on "Medical and Surgical Treatment of Prostatic Obstruction, with Report of Results of Three Years' Experience in Transurethral Resection", was given by Dr. H. O. Bratton, of Columbus.—Bulletin.

Knox County Medical Society held its regular meeting on Thursday noon, March 28, at the Alcove, in Mt. Vernon. The guest speaker was Dr. Robert L. Barnes, of Columbus, who discussed "Treatment of Arthritis". Fifteen members were present.—News Clipping.

Madison County Medical Society held a luncheon meeting at the London Country Club, on Wednesday, March 27. Dr. D. M. Johnson, Columbus, gave an interesting talk on "Common Colds".—News Clipping.

Ross County Medical Society met at Dun Glen Manor, Chillicothe, on Thursday evening, March 7, for its regular meeting. Dr. William D. Fullerton, of Cleveland, addressed the society on "Treatment of Cancer".—News Clipping.

HOSPITAL NOTES

—Improvements in the urological and radiological services at General Hospital, Cincinnati, are provided for in an anonymous gift of $22,000, according to a recent announcement by Dr. Raymond Walters, president of the University of Cincinnati.

—"Group Budgeting for Hospital Care" was discussed by Dr. Rufus Rorem, of the Julius Rosenwald Fund of Chicago, at the annual meeting of the Dayton Council of Social Agencies. Dr. W. C. Breidenbach, chairman of the health division of the Council, was in charge of arrangements.

—Dr. C. F. Woods, St. Luke's Hospital, Cleveland, was elected president, and Mr. Frank W. Hoover, superintendent of Elyria Memorial Hospital, was elected secretary and treasurer of the newly organized Northern Ohio District Hospital Association. The new association will work with the Ohio Hospital Association.

—The Elks' Club has completely remodeled its room at the Home and Hospital, Findlay. The Rotary club has purchased three new mattresses, and proceeds of a benefit bridge party were used to buy two new crank-beds for the hospital.

—Wayne County infirmary hospital, one of the FERA projects of the county, is nearing completion.

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PUBLIC HEALTH NOTES

—Cleveland Y. W. C. A. conducted a health contest, open to women of all ages, as part of an extensive program held during Health Week, April 1 to 6.

—Dr. Warren C. Briedenbach, medical superintendent of Stillwater Sanatorium, Dayton, spoke at the nine county district meeting of health workers, held in Dayton. Representatives were present from Hamilton, Butler, Preble, Miami, Darke, Greene, Clark, Champaign and Montgomery counties.

—Mrs. Mary Cartright, representative of the State Department of Health, spoke at a meeting of the Troy Mothers' Club.

—Dr. Philip A. Jacobs, of Cleveland, spoke before the Cleveland Chapter of the American Association of Medical Social Workers. Present vice conditions in Cleveland were discussed and a program outlined through which social diseases may be controlled.

—More than 500 registrations were made for the first social hygiene lecture in the series prepared by the Cleveland Parent-Teachers Association and the Council of the Academy of Medicine of Cleveland. Dr. E. A. Peterson discussed "Physical Changes in Adolescence" at the second lecture. The courses are free and open to the public.

—Akron Council, Home and School League, sponsored a children's health institute. Series of talks were given on pre-natal care, infant care, care during pre-school age, youth and adolescence.

—Review of activities of the Lorain County Health Department has been prepared by the Elyria Chamber of Comerce for entrance in the rural public health contest sponsored by the Chamber of Commerce of the United States. The report was prepared with the cooperation of Dr. F. R. Dew, county health commissioner.

—Columbus Tuberculosis Dispensary recently inaugurated a special children's clinic. Annual report of the dispensary for 1934 revealed that 3369 persons were treated, of this number, 1424 were minors.

—Dr. Sterling H. Ashmun, Dayton, spoke on "Contagious Diseases Found Among Children" before members of the Brookville Parent-Teachers Association. The meeting was devoted to a discussion of public health matters.

—Dr. J. H. Holbrook, head of the Mountain Sanatorium, Hamilton, Ontario, addressed a luncheon meeting of the Toledo Public Health Association and the Exchange Club. At the business session, Drs. B. S. Dunham, Stanley D. Giffen and O. O. Leininger were elected trustees of the Association.

New Books

Stammering and Allied Disorders, by C. S. Bluemel, M.D.; presentation of the author's investigation of stammering from the point of view of psychology and neurophysiology, the basis of the study being the conditioned reflex and inhibition; The Macmillan Company, 60 Fifth Avenue, New York City, publishers; price $2.00.

Physical Diagnosis. By Warren P. Elmer, B.S., M.D., Associate Professor of Clinical Medicine, Washington University School of Medicine, and W. D. Rose, M.D., Late Associate Professor of Medicine in the University of Arkansas, Little Rock, Arkansas. Seventh Edition. Price $8.00. The C. V. Mosby Company, St. Louis, publishers.

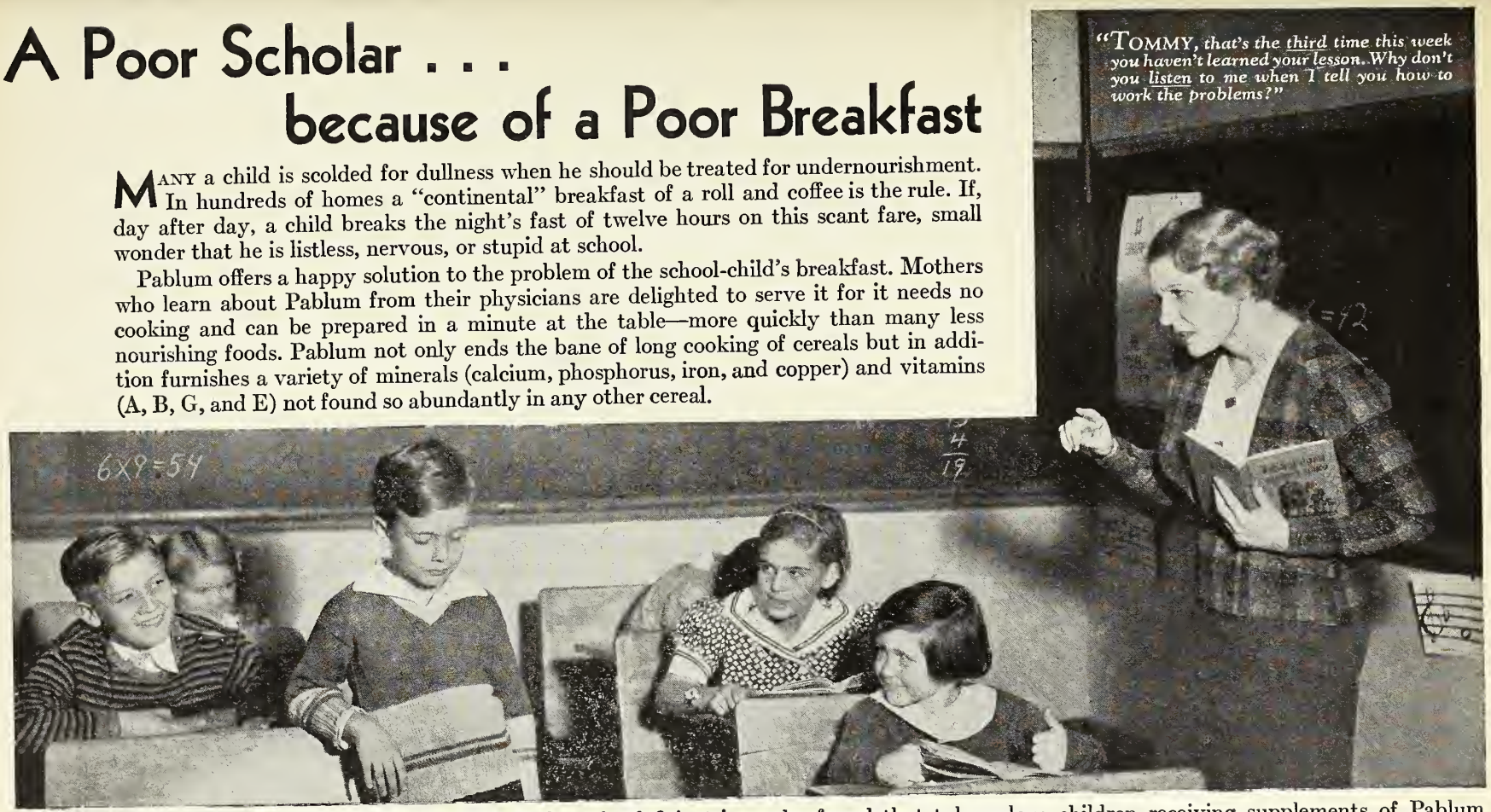
Useful Drugs: A list of Drugs Selected to Supply the Demand for a Less Extensive Materia Medica with a Brief Discussion of Their Actions, Uses and Dosage. Edited by Robert A. Hatcher, Ph.M., Sc.D., M.D., and Cary Eggleston, M.D. Prepared under the direction and supervision of the Council on Pharmacy and Chemistry of the American Medical Association. Ninth edition. Cloth. Price, 60 cents. Pp. 203. Chicago: American Medical Association, 1934.

This book represents a valuable and increasingly effective phase of the efforts of the Council on Pharmacy and Chemistry on behalf of rational therapeutics. Since its first appearance in 1913 it has become a recognized work in its field. It has been adopted as a textbook by teachers of therapeutics in the best medical schools and by various examining and licensing boards. The various editions and revisions since that time have been undertaken in the effort to keep it abreast with the advance of therapeutics. Drugs that have become obsolete have been deleted, and others the value of which has become established have been added. The statements of actions, uses and dosage of the various drugs are revised after discussion by the whole Council. They represent the latest and best results of therapeutics and pharmacologic revision. The present edition is in line with the constant aim of the Council, which has been to present a selective and informative yet comprehensive compendium of the more useful preparations in the medical armamentarium. There have been some additions to the list of drugs and a few have been deleted. Individual descriptions show evidence of careful editing. Typographically the text is an improvement on previous editions by reason of more generous spacing, which makes it easier on the eyes. As it stands, the book is an authoritative, intelligent, critical and entirely adequate textbook for the use of teachers and examiners, as well as for reference by the busy practitioner. It is an integral and constructive part of the Council's efforts in the promotion of the rational use of drugs.

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JUNE 1, 1935 VOL. XXXI Number 6

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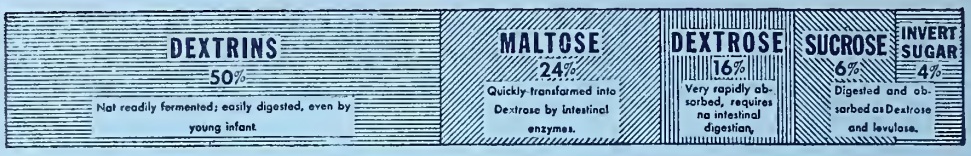
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The Ohio State Medical Journal

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PROBLEMS IN TREATMENT OF FRACTURES OF UPPER EXTREMITY

By WALTER HOYT, B.S., M.D., F.A.C.S., AKRON, OHIO

THE study of fractures is too often carried out by the demonstration of successful cases. While these results are what everyone is striving to obtain, unfortunately there are far too many bad end results. Only by the careful analysis of these latter cases also, can we hope materially to increase the number of successful results. It is not the purpose of this paper to give the treatment of all fractures of the upper extremity. Consideration of this subject is based on the examination of patients who feel that they have had a poor result. It will include simple and comminuted fractures but will exclude compound ones. When the subject is approached from this point of view, it is really an evaluation of the patient's idea of an end result, rather than that of the physician or the *X*-ray.

The chief complaints and causes for consulting the physician were not many. In the order of their frequency they were as follows: 1. Loss of function 60 per cent. 2. Pain 30 per cent. 3. Deformity 10 per cent. The first two, pain and loss of function, were by far the most frequent and the last, deformity, was relatively rare. In other words, the two things that the patient was most interested in, were function and freedom from pain.

The subject will be discussed under the following divisions: 1. Fractures of the upper end of the humerus. 2. Fractures of the shaft of the humerus. 3. Fractures of the elbow. 4. Fractures of the forearm. 5. Fractures of the wrists. 6. Fractures of the hand.

Read before the Surgical Section, Ohio State Medical Association, at the 88th Annual Meeting, Columbus, October 4-5, 1934.

FRACTURES OF THE UPPER END OF THE HUMERUS

The group of cases examined included practically all of the recognized fractures described in this region, from the most comminuted types to the very simple fractures of the tuberosities. The most predominating complaint was loss in function of the full motion of the shoulder, varying from ankylosis to limited abduction and external rotation. In practically all cases past the age of 50 years, this was associated with pain. Many cases had what should be termed excellent reduction and others would have to be classed as incomplete, but both had equally poor function and pain. Age was an important factor. By far the greatest number of cases were over 50 years of age. When a case presented himself under that age, most generally there was marked deformity with incomplete reduction and accompanying pain. In a large percentage of cases, there was direct evidence of osteoarthritis and these were all associated with pain.

The method of treatment was considered, paying particular attention to the type of immobilization. Fully 60 per cent had been immobilized by simply making the arm fast to the body with no abduction or external rotation. Some of these cases had good reductions but very poor results. In most of this group, immobilized in this manner, the arm had been held in this position for

from three to six weeks with no attempt at abduction or passive motion. A few had had prolonged physiotherapy after removal of immobilization, but many were told to simply start using the arm.

About 20 per cent had been immobilized in various methods of abduction and external rotation varying from aeroplane splints to extension and abduction in bed or with body and arm casts. The majority of these so treated, showed rather poor reductions, very severe types of fractures and a rather high percentage of osteoarthritis.

The remaining 20 per cent showed excellent reductions and had good surgical principles used in the methods of immobilization with the employment of well directed physiotherapy. In spite of this, many showed arthritis and most of them had limited motion and pain.

In small children and young adults, the disability was almost entirely associated with fractures of the neck with overriding and incomplete reduction. It was interesting to note that in spite of some very bad malpositions, the disability was relatively small, particularly in children. Several cases in adults showed untreated dislocated heads with fracture of the neck. These of course showed terrific disability.

It seems to us that some very definite lessons can be learned from this study on treatment in general of fractures of the upper end of the humerus. They can be summed up as follows:

1. Regardless of the severity of the fracture and type, limitation of motion may result, particularly in abduction and external rotation. For this reason the arm should be immobilized in abduction and external rotation. This insures the most useful shoulder even when frozen to the point of ankylosis.

2. This position should be maintained even at the expense of incomplete reduction, particularly in older people. Rarely should the arm be strapped to the chest wall.

3. If plaster abduction casts are used, immobilization should not be for over two to three weeks at which time the cast should be bivalved and passive motion started.

4. Extension in the position of 90 degrees abduction and 90 degrees external rotation with patient in bed and no splints, insures the most movable shoulder.

5. Whenever possible, complete reduction should be obtained, particularly in children and in people under 50 years of age. Open reduction is to be desired when closed reduction or extension have failed below this age.

6. Impacted fractures of the neck with marked deformity in the young adults, should be broken up, reduced and treated as any other fracture of the neck. In older people the impaction should not be disturbed and the only immobilization needed is the placing of the arm in a sling, provided that several times daily the arm is brought up into rotation and abduction.

7. Pain is often associated with arthritis. When recognized early we believe passive motion should be started as early as the second week, even at the expense of complete reduction. Pain in the absence of arthritis, is much more common in the case that is immobilized against the chest wall without external rotation and abduction.

8. Dislocation of the fractured head is a serious problem and open operation is to be considered at practically all ages except the extreme aged.

FRACTURES OF THE SHAFT OF THE HUMERUS

A relatively small number of cases presented themselves because of complaints of fractures in this region. Those fractures immediately adjacent to the elbow or shoulder were not included in this group. The causes of complaints in the order of their frequency were as follows: 1. Limited function. 2. Deformity. 3. Pain. 4. Nerve injury. 5. Non-union.

1. Limited motion was found to be almost entirely located in the elbow and varied from almost complete ankylosis to a few degrees in flexion or extension. In older people, limitation in motion was found in the shoulder. This limitation was present in spite of the fact that all fractures extending into the joints were excluded.

2. Deformity was present in practically all cases and consisted in lateral or medial bowing, torsion and anterior or posterior angulation. While the patient complained of deformity, in most cases when it was present, it was more the associated limited function that concerned him.

3. Pain was rare and practically never at the site of fracture but in the elbow or shoulder.

4. Nerve injury was in all cases limited to the musculo-spiral except in two cases involving the brachial plexus following avulsion at the time of injury. The resultant disability was obvious.

5. Non-union cases naturally complained of the lack of stability of the arm and loss of function. Pain in these cases was not common.

Examination of the *X*-rays in this group showed rather startling malpositions, varying from overriding up to two inches with wide separation, to angulation in all four directions. In spite of this, good bony union was present in all but a very small group of the non-union cases. At least 90 per cent of the cases having limited motion had definitely poor alignment or angulation. Those having posterior bowing had the most difficulty in extension of the elbow and those with anterior bowing, limited flexion. Lateral and medial bowing when present, did not seem to affect the function of the elbow to any great degree but left an awkward arm limited in the normal motions. These latter bowings were often associated with torsion of the distal fragment. A rather small group showed perfect alignment and reduction but limited motion in elbow or

shoulder. The non-union *X*-rays showed in many instances loss of bone tissue, evidence of osteomyelitis, separation and the presence of metal bands, plates and screws, wires and bone grafts.

The review of the treatment of this group showed various methods employed. The most common dressing used was strapping to the body with coaptation splints for a period of three to four weeks with infrequent dressings and not much attention given to motion in the elbow or shoulder. A few cases were treated by extension with the arm in the straight position. These cases generally showed anterior bowing at the site of the fracture. Others treated by extension with flexed elbows, showed many posterior bowings but a more useful elbow. Those treated by body cast and in more abduction showed more lateral and median bowings. It was an interesting fact to note that a rather large majority of cases, once they had been put up in one of the above manners, were not disturbed in spite of the fact that check-up *X*-rays showed definite deformity. In very few instances were anesthetics given.

The non-union cases as to etiology were classed as follows: 1. Cause unknown. 2. Compound fractures. 3. Open reduction with some method of fixation. 4. Arm extension.

The musclo-spiral nerve lesions were classed as follows: 1. Primary injury unrecognized. 2. Primary injury operated but failure. 3. Secondary lesion coming on late. 4. Secondary lesions coming on after open reduction. In three cases the operative exposure was from the posterior lateral approach.

We feel that we can draw some conclusions from this group of fractures of the shaft of the humerus.

1. Loss of function is usually the result of poor alignment of the fragments. Angulation and bowing should be corrected even though it is necessary to resort to a different type of dressing. This type of deformity is more important than overriding. If necessary, repeated anesthesia should be used and the reduction is best accomplished immediately after injury. Most of the angulation can be corrected by wedging the cast after reduction if check-up *X*-rays are not satisfactory.

2. In our opinion a body cast with abduction is the dressing of choice, if fracture can be satisfactorily reduced. Dressings to the body wall are more apt to result in angulation and limitation of the shoulder or elbow. If extension is necessary, it should be with the elbow flexed either in bed or with a walking splint or cast. No case should be left in the extended position.

3. Open reduction is rarely indicated and once performed increases the danger of non-union and nerve injury. If indicated, an anterior incision should be made and if possible, no internal splints used.

4. Nerve injury should be looked for in each case and if found, nerve suture considered immediately. Those coming on late should be taken care of as they appear. They are usually the result of callous formation.

FRACTURES IN THE REGION OF THE ELBOW

In this group are included all injuries to the lower end of the humerus and the upper end of the radius and ulna. It is impossible to consider all fractures separately but they will be grouped according to the age of patient.

A rather large number of fractures in children was seen. Here also loss of function was the predominating complaint. Pain was seldom encountered but deformity was a prominent occurrence. The severest disability in this series consisted of complete ankylosis at the elbow with loss of supination and pronation. Some of these cases were found in complete extension and all positions, up to acute flexion. When not ankylosed, there were all variations of limited motion, from a few degrees of motion to slight limitation in extension or flexion. Angulation toward the median line, causing a change in the carrying angle was common. Five cases were grouped under Volkman's ischemia contractions and were all associated with limited motion at the elbow, as well as the typical disability of the forearm and hand. All of these showed scars varying from slight breaking of the skin, up to areas extending completely through the muscles of the forearm down to the bone.

The deformities in this group consisted in angulation of the elbow either medially or laterally, prominence of the inner or outer condyle and either extension or flexion of the elbows on the humerus. The deformity of Volkman's contracture was typical.

In adults, the same types of loss of function were observed. There was a much larger number of complete ankylosis of the elbow and more cases with limited supination and pronation. The percentage of flexion and extension was also less and very few of them, when limitation was present, were able to get up beyond a right angle. The deformities were much the same except that in many cases the normal bony landmarks were farther out of alignment.

In children, studies of the *X*-rays showed very consistently, two things: A. Incomplete reduction of the proximal and distal fragments of the humerus, with either lateral or medial displacement of the distal fragment in the anterior posterior view, or forward or posterior displacement in the lateral view. B. Displacement and detachment of either the internal or external epicondyles, with rotation. This was associated with a definite growth and developmental disturbance of the lower end of the humerus.

There were a few fractures of the head of the radius associated with widening and deformity of

the head. The fracture of the ulna was an uncommon finding.

In adults, the *X*-ray findings showed too large a variation to enumerate. Here too was shown the fact that there was a very large percentage of incomplete reductions. When there was ankylosis or marked limitation of motion, the fracture was almost invariably intra-articular and in many cases was associated with considerable bony proliferation. In the cases of multiple fractures of the elbow, several cases showed wide separation of the fragments of the lower end of the humerus, associated with a large deformed head of the radius and an incompletely reduced fracture of the ulna. Both the ulna and radius were seen singly, involved with separation and deformity. Some cases showed loose fragments of bone in the joint where it was difficult to determine their origin. Many showed very satisfactory reductions but were associated with obliteration of the joint surfaces and evidence of bone proliferation and arthritis.

The types of treatment and immobilization were so varied in this group that they can only be described in a general way.

In children, while early attempt at reduction was carried out in most cases, many were allowed to go for from twenty-four hours to two weeks before reduction was attempted, the reason given in most of these cases being swelling. This was particularly true in the supracondylar types. After reduction, a rather large proportion were put up at a right angle or less and immobilized in metal splints or plaster. Very few were put in acute flexion. In the cases where one of the epicondyles was fractured, in only one instance was open reduction resorted to. Where Volkman's contractures resulted, metal splints were used and all complained of severe pain for the first twenty-four to forty-eight hours. The dressings were not changed for a number of days, varying from three to eight. It was interesting to note how comparatively few of this group were treated with the aid of the fluoroscope and in how many check-up *X*-rays, were reported incompletely reduced. In spite of this, further attempt at reduction was not made. In many cases the treatment seemed to be ideal and immobilization good.

In adults, the treatment consisted usually in closed reduction followed by some type of plaster or metal splint immobilization. Repeated attempts were carried out in some cases and open operation was resorted to in a number of instances. This was particularly true in the ulna. In two instances, nailing of the lower end of the humerus was done and in one case, traction by means of a wire through the olecranon, was instituted. Position of immobilization varied from acute flexion to almost complete extension. The majority were put up in a position less than right angle flexion. Physiotherapy was carried out in a majority of cases but mobilization was generally delayed until after four weeks.

The conclusions that can be drawn from these cases are as follows:

1. In supracondylar fractures in children, early reduction is essential. By mean of the fluoroscope the best reduction can be carried out. Particular care should be exercised to correct the lateral displacement of the distal fragment, as well as the anterior posterior one. The arm should be put up in acute flexion. A test of reduction is when the little finger points or can touch the acromiom process. This position can be easily maintained by the Ashurst bandage and does not necessitate the use of metal or plaster splints. When the fracture is seen later and swelling has taken place, the reduction should be carried out and the arm put up in as much flexion as possible, the amount depending on the radial pulse. When swelling has subsided, further flexion can be obtained and repeated reduction done until satisfactory by *X*-ray examination. Volkman's contracture is the result of pressure or too tight bandages and splints. It can be prevented by use of the Ashurst bandage or similar dressing and careful observation of the radial pulse. Pain should never be ignored and dressing changed if necessary.

2. In children, fracture of the epicondyle with rotation, should be treated by open operation.

3. In adults, early reduction should be attempted and as near anatomical relations obtained as possible.

4. Ankylosis and marked limitation of motion is more common in adults than children. For this reason, the position of optimum function should be maintained, even at the expense of reduction.

5. In cases of multiple fractures of the elbow involving the lower end of the humerus, the olecranon and the head of the radius, it is our opinion that the olecranon should be reduced by open operation and sutured or nailed at once. The fracture of the humerus should be treated conservatively and the fracture of the radius treated by open removal at a later date if necessary. By this method, early motion can be instituted with more hopes of normal function.

6. Physiotherapy and motion should be started early in all elbow injuries.

7. Many late cases with disability in adults and children, can be improved by operative measures, such as osteotomies, reconstruction operations and removal of the head of the radius.

FRACTURES OF THE FOREARM

The cases examined in this group complained mostly of loss in the normal use of the forearm, particularly limitation in either pronation, supination, or both. Limitation in motion of the wrist was more common than at the elbow. Pain was not a common complaint. Deformity was, however, a more common complaint than in any other location with the exception of the wrist.

A study of the *X*-rays revealed some of the following conditions: 1. Fracture of the ulna with overriding associated with dislocation of the head of the radius. 2. Fracture of the upper end of the radius with torsion of the distal fragment into complete pronation. 3. Fracture of either the radius or ulna with shortening uncorrected. 4. Angulation of a single bone, with widening of the interosseous space. 5. Fracture of the upper end of the radius, above the insertion of the pronator radii teres, with wide separation and deformity. 6. Fracture of both bones of the forearm with all types of reduction, varying from perfect anatomical position to overriding, cross union and bowing. While there was synostosis in a few of the cases, the one most predominate factor was that there was either narrowing of the interosseous space or that there was variation in the normal alignment of one or more of the four fragments. Torsion of one or both of the bones was observed. 7. Non-union was seen in both the radius and ulna. Most of these followed open reduction. The cases where synostosis had taken place were the comminuted types or where multiple fracture lines were present.

The types of treatment varied, as well as the immobilization. Reduction under anesthesia was carried out in most cases but in only 30 per cent was reduction repeated even with a more or less unfavorable *X*-ray. About 5 per cent of the cases showing overriding, had had some type of extension applied although this was not common. Open operation had been done in a few cases, either by wiring, plates or simple reduction without fixation.

Immobilization varied from wire, metal and wood splints, to moulded and circular casts. In fractures of the upper forearm, about one-half of the cases had anterior and posterior splints above the elbow. The others had simple forearm fixation. Fractures below this point, usually had only forearm splints. The usual flexion of the elbow was 90 degrees. It was difficult to determine the degree of pronation or supination but it appeared that the majority were put in the mid-position. It was attempted to ascertain the length of the splint as regards the wrist and fingers. In the majority of cases it was carried down over the metacarpals and in some, over the phalanges.

The length of time of the first dressing varied from the first twenty-four hours up to four weeks. Re-check *X*-rays were taken in many cases in one week, some at the time of removal of dressings and many had no re-check taken. Physiotherapy was instituted about 50 per cent of the time. Passive motion during the period of immobilization was a rare finding.

We believe we can learn many things from this group and venture to make some suggestions as to how the treatment in general, could have been improved.

1. In fractures of the upper end of the ulna alone, with shortening, dislocation of the head of the radius occurs. If not detected and treated, a bad result follows.

2. In simple fractures of the radius, location is of importance. When above the attachment of the pronator radii teres, fixation is best made in supination with splints extending above the elbow. Below this point, a mid-position is permissible.

3. If both bones of the forearm are fractured, the problem becomes more difficult. In such fractures there are four movable fragments. The success usually depends on how well reduction can be accomplished by maintaining alignment, width of interosseous space and preventing torsion of any fragment. Anatomical reduction should be sought in all cases and if repeated manipulation does not produce it, some method of extension should be applied. Open operation is indicated in a certain percentage of cases. These fractures are severe and one should not hesitate to hospitalize some of these patients, so that proper methods of extension, either conservative or radical, can be used to obtain better reduction. No fixed rule can be followed, for the amount of pronation or supination. It must be determined by the appearance under the fluoroscope or *X*-ray findings. It appears that many of the cases presenting themselves with impaired function, were the result of incomplete reduction.

4. A variety of splints may be used. Our preference is the moulded plaster splint, since it is easily adaptable to any arm and can be varied for any case or condition. Before they harden, they can be moulded and the position of the bones can be changed under the fluoroscope. They more nearly follow the normal contour of the hand and wrist and do not cause flattening. They are easily removed for inspection and passive massage or motion. Both an anterior and posterior splint are desirable and should extend from well above the elbow to the metacarpal phalangeal joint, except when the fracture is located far down in the arm. They should not include the tips of the fingers, restrict motion, or cause pressure on the tendons.

5. The fluoroscope, repeated *X*-rays and physiotherapy, will be a great aid in obtaining better anatomical reduction and better functional results.

FRACTURES OF THE WRIST

Cases of this group complained of—1. Limited function. 2. Pain. 3. Deformity—in the order of their frequency.

Loss of normal function of the wrist was of all degrees, varying from complete fixation to slight difficulty in flexion or extension and lateral motion. Some of the wrists were fixed in pronation and some in supination. It seemed that the worst disability was that of marked pronation and flexion, while the best was that of semi-

pronation and supination. Extension of the wrist was the motion most often affected and radial deviation more common than ulnar deviation. All degrees of limitation of the fingers were found. One other common complaint of disability was that of limitation in motion of the shoulder joint, especially in abduction. This was particularly common in older people and was a cause of much trouble to them. In a number of this group there was no disability except the shoulder.

Pain was particularly common in people past fifty and was located in the shoulder, forearm, wrist and fingers. The majority complained only on manipulation or attempted motion. Others had pain at rest and in motion. A most constant and common site of pain was over the styloid process of the ulna, particularly on ulnar deviation.

Deformity while not often the chief complaint, was of course present in practically all. The most common was radial shortening and was associated with thickening of the lower end of the radius either dorsally or laterally.

X-ray findings revealed in some instances, what would appear to be perfect reduction of the fracture. The majority however, showed some deviation from the normal. The common abnormalities present were—1. The styloid of the radius did not extend downward to its normal position. 2. There was impaction of the lower end of the radius. 3. There was rotation of the lower end. 4. The articular surface of the lower end of the radius was reversed in the way it faced. It faced upward, backward and outward, instead of downward, forward and inward. 5. Separation and non-union of the styloid of the ulna. 6. Arthritis and bone proliferation. There were other deviations from the normal, such as incomplete reduction of epiphyseal separations and gross displacements of the whole contours of the wrist, but the above were the most common findings.

Treatment had consisted in closed reduction as a rule. There was a fairly large group in which no anesthetic was given, particularly in older people. Repeated reduction was not the rule and many were not done with the use of the fluoroscope. Immobilization varied from cock-up position to neutral position, from marked flexion to ulnar deviation. Metal and wood slpints, moulded and circular plasters were used. The time of immobilization varied from two weeks to eight weeks and the first dressing varied from one day to six weeks. Some moulded splints were changed to other positions at the end of ten days. Most of the patients carried their arms in slings and a very small number had been instructed to use the arm or shoulder during this period. Check-up *X*-rays were used often but many cases had no *X*-ray after reduction.

From our own experience and the observation of these cases, we feel that there are some rather definite principles and procedures which should be used and that with these, the number of disabilities could be materially lessened.

1. In reviewing this group, one is impressed with the large number of incomplete reductions and the fact that more attempts were not made to correct the deformity of the lower end of the radius. Every effort, even with repeated attempts, should be made to approximate complete reduction. Especial attention should be given to the position of the styloid of the radius and the angle of its articulation. The radius should be elongated instead of elevated.

2. Complete anesthetic, either local or general, should be used. The older the individual, the more important it is to get complete reduction.

3. When there is a fracture of the ulnar styloid, the wrist should be immobilized in ulnar deviation.

4. Moulded plaster splints should be used, well fitted to the hand and wrist, leaving free motion of the thumb and fingers. The splints should not compress or constrict the soft tissue and tendons of the back of the hand.

5. The position of choice is midway between pronation and supination. The wrist should not be left in ulnar deviation or acute flexion for too long a period.

6. Frequent dressings should be done, preferably every two to three days and passive motion should be instituted early.

7. The fluoroscope should be used in the reduction of these fractures and re-check *X*-rays taken after reduction, and ten days later.

8. The patient should be instructed to put the hand above the head several times a day and he should be encouraged to use his arm rather than carry it in a sling.

9. Many of the so-called poor end results, can be improved by forcible reduction with correction of the malposition.

10. Arthritis is a troublesome complication of the wrist, particularly in older people. Pain is associated with this. Early establishment of activity is desirable when discovered at the time of injury.

FRACTURES OF THE HAND

While these fractures have always been considered more as minor injuries, end results are often very bad. A rather large number were seen. Space does not permit a complete discussion in this paper. Very severe loss in function and deformities were observed. The condition most commonly seen was incomplete reductions of metacarpals and phalanges, fracture of the scaphoid and dislocation of the semilunar bone with associated fractures of the carpal bones. In several cases, the dislocation of the semilunar bone had not been diagnosed. Our feeling on fractures in this region, is that they should be considered more seriously and that better methods of reduction, extension and observation should be carried out.

When the function of a hand is at stake, it can no longer be considered as a minor fracture and deserves all of the attention of a fractured elbow.

In making any general conclusions of this study, one has to bear in mind that all the cases considered, had bad end results, the good results being excluded. It is impossible to estimate what percentage of the whole they represent. They do not represent the practice of one man or method of treatment. They were seen anywhere from six months to twenty years after the original injury, during which time radical changes in fracture treatment have taken place. We recognize that we are unaware of the circumstances in connection with each case or the cooperation on the part of the patient. It has not been our thought to criticize anyone or any method of treatment, but to determine if possible, what are some of the reasons for our poor end results.

CONCLUSIONS

1. The patient is particularly interested in good function and freedom from pain.

2. In spite of limited function complained of by the patient, many cases from a medical standpoint, have to be rated as good results.

3. Many cases had incomplete reductions as shown by *X*-ray and further attempts at correction had not been made. Hairline reduction was not the basis for judging incomplete reductions. They were considered incomplete when normal alignment was changed, or when the normal relations of the joint surfaces were altered.

4. Immobilization and splinting in many instances was not based on sound principles of mechanics and optimum positions for function were often ignored.

5. The use of the fluoroscope and repeated check-up *X*-rays are of great assistance in obtaining more accurate reductions. Both anterior-posterior and lateral positions should be taken. The true condition can not be determined by one direction.

6. No fixed method can be outlined for each fracture. The treatment should be varied to meet the situation. Radical treatment has its place in selected cases when conservative measures have failed.

7. Complete anesthesia should be used in practically all cases.

8. While most cases can be made ambulatory, it should not be made a tradition. Hospitalization is often necessary in order that the patient and physician may take advantage of some of the recent advancements of fracture treatment.

9. Arthritis, faulty position, pressure, too prolonged immobilization and faulty splinting, are some of the causes of pain.

10. Many of the bad end results can be relatively improved by further orthopedic surgery.

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CONVULSIONS IN INFANCY

*A Statistical Study of Four Hundred Cases**

By JOHN E. BROWN, JR., M.D., COLUMBUS, OHIO

HOW often has each one of us been summoned to the home in consultation or to the wards of the hospital to see an infant, critically ill, whose only diagnosis is "convulsions"? In reality, convulsions are essentially a symptom-complex of some pathological disorder in the body, not always obvious at first examination. It is surprising, however, how often the etiological factor can be determined, and it is of the utmost importance to discover this factor as quickly as possible in the case of the convulsing infant, for frequently our therapy to be successful must be modified according to the diagnosis made.

In order to evaluate the convulsing infant, we should have some general idea of those pathological disorders most frequently accompanied by convulsions. The recent literature on the subject, with the exception of Peterman's series[1], has been rather inadequate, and for this reason it would seem in order to present additional and fuller information on the etiology of infantile convulsions.

For this purpose, 2279 consecutive records at the Infants' Hospital, Boston, Massachusetts, were reviewed, and in this series, 400 cases were found that presented a history of convulsions in the few days preceding hospital entry or during their period of institutionalization. Only those cases were included that had an unquestioned story of either generalized convulsions or persistent clonic motions of one or more of the extremities. The group investigated comprised only babies up to two years of age, and covered entries into the hospital over a period of roughly 38½ months, from April 18, 1931, to June 30, 1934. In

*From the Infants' Hospital, Boston, Massachusetts, and the Department of Pediatrics of Harvard Medical School and the Department of Pediatrics of Ohio State University College of Medicine.

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these 2279 infants, we find 400 with convulsions, or 17.6 per cent, a startlingly high figure. The ages given refer to the month of life in which convulsions were first described.

In Chart I it will be noted that acute infection is by far the most common cause of infantile convulsions, accounting for 30 per cent of the entire group. And if we were to include those babies whose latent tetany was rendered active by acute infection, and the associated disorders grouped under "Miscellaneous" in which terminal infection has played a major part in causation, our figure would be closer to 35 or 40 per cent.

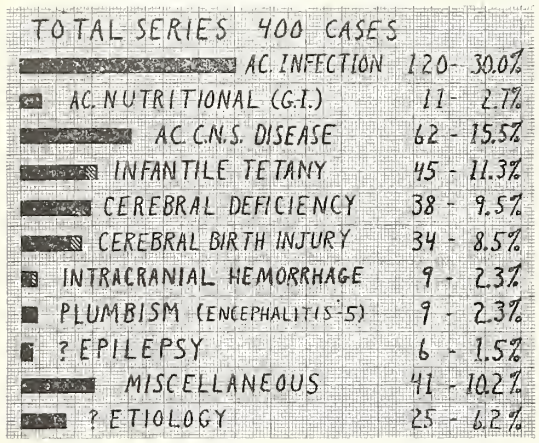


Chart I. Etiology of convulsions in total series: 400 cases.

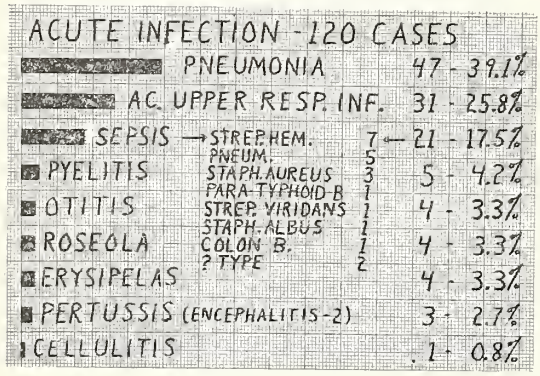


Chart II. Types of acute infection precipitating convulsions: 120 cases, 30.0 per cent of total series.

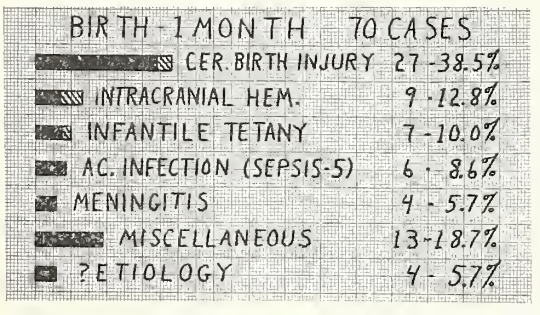


Chart III. Etiology of convulsions in infants from birth to one month of age: 70 cases, 17.5 per cent of total series.

Pneumonia is by a large margin the most common infection accompanied by convulsions, as is shown in Chart II. This disease is followed by the acute upper respiratory group, in which are included coryza, pharyngitis, tonsillitis, and the various disorders of the upper air passages, with the exception of otitis media which is separately classified. Sepsis is the third most common type of infection noted, with the hemolytic streptococcus and the pneumococcus sharing first honors. It is interesting to note that in infancy, such a supposedly innocuous organism as staphylococcus albus—verified by pour-plate blood cultures—may cause serious difficulty. Otitis media —and we here refer to primary otitis, and not to the secondary or terminal otitis so common in seriously ill infants at this age—and pyelo-nephritis, oft quoted among the principal causes of meningismus, are infrequent in our study. It is rather remarkable to discover roseola infantum as the etiological factor in four cases.

When one further subdivides the cases into the three age-groups: birth to one month, one to six months, and six months to two years, as is shown in Charts III, IV, and V, it becomes obvious that acute infection plays its smallest role in the neonatal period, when sepsis, usually secondary to aspiration or to a failure of the umbilical barrier, accounts for five of the six cases noted. After this time, sepsis becomes comparatively less frequent, and broncho-pneumonia and the upper respiratory group supplant it as the most frequent trouble-maker.

Acute intestinal disorder, or alimentary intoxication, accounting for only 2.7 per cent of the convulsions, is given second place in our classification for the reason that this group probably is a manifestation of enteric infection, and should properly be included under the heading of "Acute Infection". Recent investigations by a Toronto group [2] and by workers at Cincinnati[3] are quite suggestive of this hypothesis. In reviewing these records it is interesting to note that the majority of these cases appeared in the one to six months group, and only in the very critically ill infants, most of whom died shortly after the onset of convulsions.

Fifteen and five-tenths per cent of the entire group was classified under "Acute Central Nervous System Disease". In Chart VI, we find that the majority of these cases are of course meningitis, and it is interesting to observe that the influenza bacillus was first offender, followed closely by the pneumococcus and the tubercle bacillus. The hemolytic streptococcus and the meningococcus were a poor fourth and fifth in standing. These relationships are apparently due to the almost 100 per cent incidence of con-

vulsions with the first three named, rather than to a markedly higher morbidity rate. The atypical types of meningitis described in the neo-natal period, usually with organisms of the enteric group, are represented by a case of mixed infection with the pneumococcus and Flexner organism, with symptoms beginning on the second day of life.

There were five cases of acute encephalitis not classifiable elsewhere, and we should mention also five cases accompanying lead poisoning and two with pertussis. There was but one case of poliomyelitis with convulsions, although the disease was not uncommon on the hospital wards in the summer of 1933. No cases of brain tumor or abscess in this age-group were found.

Infantile tetany or spasmophilia accounted for 11.3 per cent of the total. Forty-five cases were included, of which 38 are considered as "verified" and seven as "probable". The unquestioned cases are those in which the serum calcium was found to be 7.5 mg. or less per 100 c.c. of blood; and the "probable" cases are those with calcium values between 7.5 and 8.5 mg., those with positive electrical reactions—cathodal opening contraction under 5 milli-amperes—and one case in which there was prompt response to specific medication, with no other cause discoverable.

We are rather prone to think of tetany as a disease of rare occurrence in very early infancy. Rothstein[4] has reviewed the recent literature and found only three cases under three weeks old with symptoms of acute infantile tetany, in which there was demonstrated an appreciable lowering of the blood calcium. He added another case to this series, and Craig[5] described a fifth case not included in Rothstein's series. There are several descriptions of syndromes simulating tetany in the early neo-natal period, with symptomatic improvement reported after specific therapy, but in these instances calcium determinations were either not made or were within normal limits. Shannon's[6] recent article is the most comprehensive along this line.

It was hence very surprising to discover that over half of our cases became manifest in the first four months of life, and that tetany was quite infrequent after one year. This is graphically shown in Chart VII. Seven and 12 cases respectively in the first and second months indicate the importance of thinking of tetany as a cause of convulsions even at this tender age. Among the cases in the neo-natal group, the following is quite interesting because of the very early date of onset, and the fact that the baby was full term and receiving some breast milk.

CASE REPORT

M. M. was a three-weeks old female infant admitted May 1, 1934, with complaint of convulsions of 12 days' duration. Baby was full term, easy low-forceps delivery, and had no disturbances indicative of birth injury. She was on breast with supplementary formula, and was apparently thriving when intermittent generalized convulsions began on the ninth day of life. No feverishness or other symptoms of infection had been noted, although the convulsions became progressively more frequent and prolonged. At entry, she weighed 8-4, was well developed and nourished, and showed no abnormalities on complete examination except for marked spasticity. Trousseau's and Chvostek's signs were not elicited, and there was no definite carpo-pedal spasm. White count

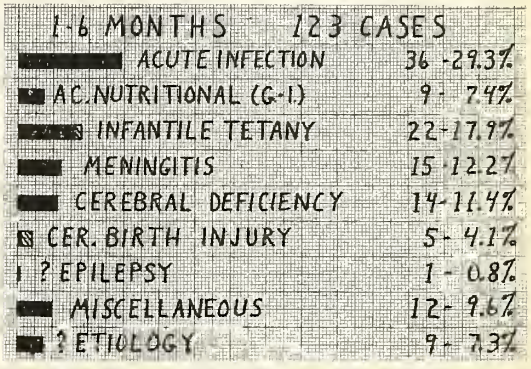


Chart IV. Etiology of convulsions in infants from one to six months of age: 123 cases, 30.7 per cent of total series.

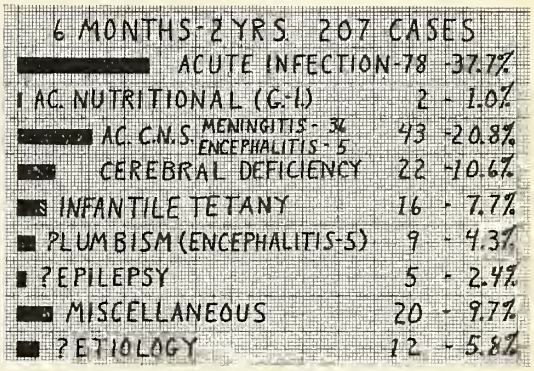


Chart V. Etiology of convulsions in infants from six months to two years of age: 207 cases, 51.8 per cent of total series.

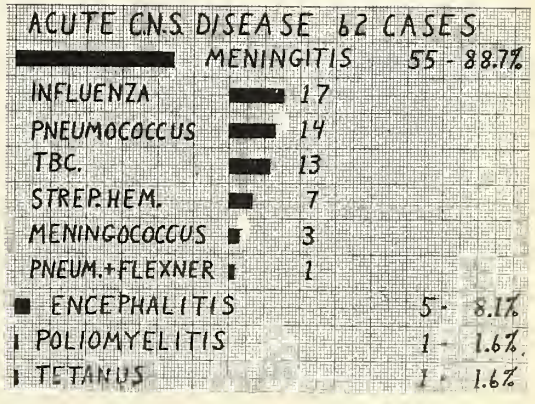


Chart VI. Types of acute central nervous system disease precipitating convulsions: 62 cases, 15.5 per cent of total series.

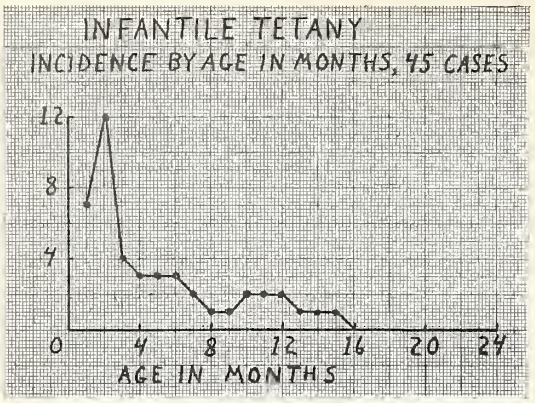


Chart VII. Incidence of infantile tetany by age in months.

was 18,000 with 37 per cent polymorphonuclears; urine, Wassermann, Mantoux 1:1000, and spinal fluid all negative. Blood calcium was found to be 5.1 mg. at time of entry, and 6.6 mg. next day. Accordingly 5 c.c. of calcium gluconate was given intramuscularly, and calcium chloride gr.X, and viosterol started in each feeding. There were no further convulsions. Blood calcium levels were normal at time of discharge two weeks later.

Holt and McIntosh[1] state that "rickets can be demonstrated—either clinically or roentgenologically—in practically every case of infantile tetany". In our series, there was a frequent but not invariable association. Even in the age-group under four months, 57.1 per cent of the verified cases had rickets demonstrated by *X*-ray, as listed in Chart VIII. In the older age-group, the percentage is of course markedly greater, being 83.3 per cent. These figures tell us in no uncertain fashion that cod liver oil or its equivalent should be started at least by the third week of life, even when infants are being nursed.

Chart IX is instructive in that it shows us that acute infection is another frequent companion of active tetany. Up to four months, over half of the cases of verified tetany showed some definite evidences of infection; whereas almost three-quarters of the older age-group had their convulsions appear at the onset of infection. The infection precipitating active tetany may be of any type, although the acute upper respiratory group and broncho-pneumonia were the most common in our series. In the total group, and in the one to six months series, we include one case respectively of acute nutritional disturbance and one of obstructive jaundice. The first probably represents, as before mentioned, a manifestation of enteric infection, and the latter is an evidence of deficient absorption of Vitamin D contained in fat, which we know is poorly digested and assimilated in the presence of biliary dysfunction.

It is, therefore, important in all cases of acute infection with recurrent convulsions to exclude spasmophilia, for the seizures will frequently reappear, notwithstanding our routine treatment of them with sedatives, unless specific therapy is started. This preferably commences with calcium gluconate intravenously or intramuscularly, followed by calcium chloride in small doses in the feedings, plus viosterol. The calcium gluconate rather quickly raises the calcium levels in the blood up to a point where convulsions no longer occur, and the chloride produces an acidosis which withdraws calcium from the reservoir in the bones and transfers it to the blood stream, thus maintaining the increased level initiated by the calcium gluconate. The viosterol of course aids in the general metabolism of calcium and phosphorus, and will eventually maintain the blood calcium at normal levels and restore the depleted reservoirs in the bones.

In Chart X, the incidence of infantile tetany in months of the year is shown. As was to be expected, we have a higher incidence in the early spring months when rickets heals spontaneously, with resultant transfer of calcium from the blood stream to the bones and lowering of the blood calcium levels. The very high number of cases in

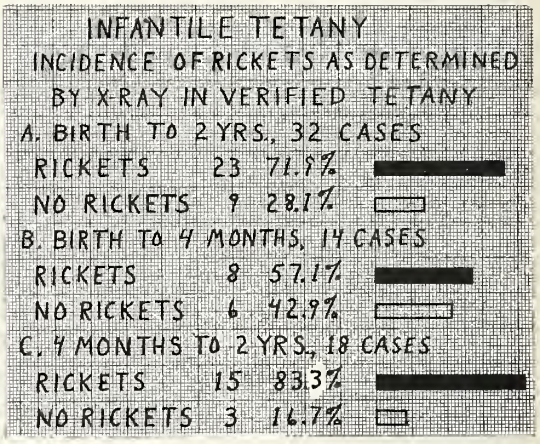


Chart VIII. Incidence of rickets as determined by X-ray in verified infantile tetany: in 0-24 months age-group, in 0-4 months age-group, and in 4-24 months age group.

January is probably best explained by the fact that this month was characterized by a marked increase in admissions with various types of infection. From our figures, we would conclude that three-quarters of infantile tetany first manifests itself during the winter and early spring; possibly we might suggest that there is both a winter and a spring peak to the disease.

Cerebral birth injury is credited with only 8.5 per cent of the entire series, although, in the neonatal group, up to one month of age, it is responsible for 38.5 per cent of the convulsive episodes. Of the 34 cases listed as birth injury, 27 are considered as "verified", and seven are "probable" with a suggestive story of difficult or instrumental delivery.

It would be well at this time to mention nine

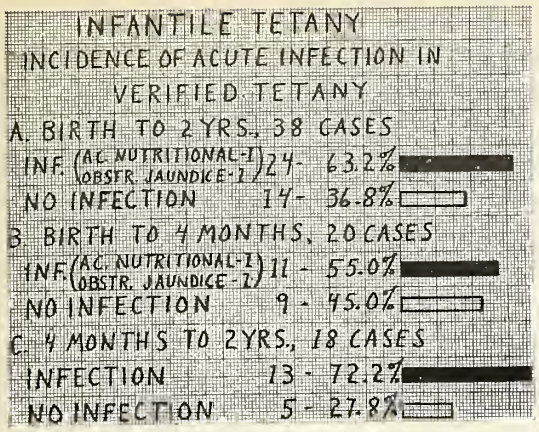


Chart IX. Incidence of acute infection in verified infantile tetany: in 0-24 months age-group, in 0-4 months age-group, and in 4-24 months age-group. Included is one case each of acute nutritional disturbance and of obstructive jaundice.

cases, comprising 12.8 per cent of the early age-group, that are classified under "Intracranial Hemorrhage". Of the nine, five are considered as "verified" with repeated subarachnoid taps showing uniformly bloody fluid, and four are considered as "probable" with only one puncture performed, although the findings indicated subarachnoid hemorrhage rather than trauma. It is probable that most of these cases are due to birth injury, but that some of them may be caused by other disorders is evident when we find three infants with bloody subarachnoid fluid, two of them having obvious hemorrhagic disease of the newborn and one erythroblastosis foetalis.

"Cerebral Deficiency" is the designation of 38 cases, or 9.5 per cent of the entire series. Babies, so classified, are usually retarded in their mental development, and all but the most hopeless cases have been corroborated by encephalograms which revealed definite pathological changes with increase in size of the ventricles. These cases constitute 11.4 per cent and 10.6 per cent respectively of the two older age-groups. From a study of the individual records, it appears that most of these owe their mental deficiency to trauma or asphyxia at birth. However, a few of them are known to be definitely post-infectious or encephalitic in character, and others are of congenital origin. The exact etiology can usually be surmised from the history but seldom proved, and occasionally even the autopsy table fails us, as will be pointed out. Hence it seems wisest to classify these unfortunate cases under the general term of "Cerebral Deficiency".

The following case illustrates the difficulty of exactly determining the etiology of cortical degeneration even at autopsy, and warns us of the danger of too enthusiastically blaming birth trauma for all convulsions in the neo-natal period. In this instance, the cerebral defect was probably of intra-uterine origin and developmental.

J. F. was a 2½ week old male infant admitted on January 25, 1932, with complaint of diarrhoea and vomiting of two days' duration. He was a full term baby, delivered without instruments after an easy 9-hour labor; birth weight was 6-8; and his immediate post-natal condition seemed excellent. On the fourth day of life he became apathetic, and shortly thereafter developed projectile vomiting and severe persistent convulsions. He was admitted to another hospital with presumptive diagnosis of "thymus", but *X*-rays were found to be negative, and he was discharged after ten days apparently symptom-free. On the 16th day, he again appeared very apathetic, and developed a severe diarrhoea with vomiting. At entry, the baby was acutely ill, showing marked dehydration and emaciation, had cold and cyanotic extremities, and was in a state of marked acidosis as shown by blood CO_2 of 11 vol. per cent. Treatment consisted of parenteral fluids and two transfusions, but the baby's condition remained critical, with death occurring after 3½ weeks in the hospital, presumably from a terminal broncho-pneumonia.

The pathological report at autopsy stated that "the most interesting and unusual findings are referable to the skull and brain . . The brain does not completely fill the cranial vault. Grossly, it is small, much diminished in weight, and definitely abnormal in contour . . Cystic areas of degeneration are scattered throughout the brain substance. The cortex shows great variation in thickness. The degenerative areas show varying degrees of repair. Focal areas of calcification in nerve cells, in the walls of blood vessels, and in areas of degeneration in the brain substance are very puzzling. The gliosis, which has replaced a portion of the ependyma, suggests inflammation as being the fundamental process. Intracranial hemorrhage can hardly be blamed for the pathological lesions. There are anomalous bands of peritoneum in the abdomen and the course of the duodenum is anomalous . . Any interpretation of this case is debatable."

Another type of case, in which cerebral deficiency of unknown etiology was found, is illustrated below. From the previous case report, it should be evident that we are not justified in definitely assigning the condition to injury at birth.

J. K. was a 4-months old male infant admitted August 7, 1932, with complaint of convulsions of six weeks' duration. Baby was delivered by low

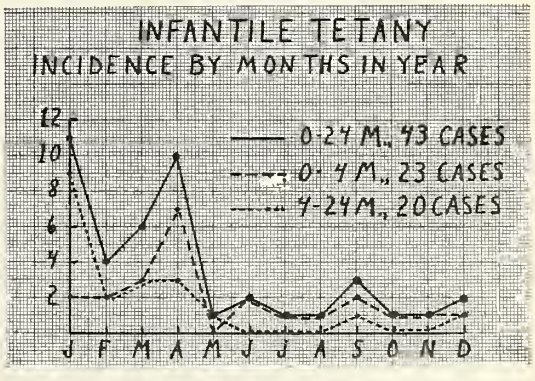


Chart X. Incidence of infantile tetany by months in the year; in 0-24 months age-group, in 0-4 months age-group, and in 4-24 months age-group.

MISCELLANEOUS	41 Cases
Congenital Heart Disease	5
Sinus Thrombosis	4
Subdural Hematoma	4
Congenital Lues (Meningitis—2)	4
Hydrocephalus	3
Inanition Fever	2
Hemorrhagic Disease (Intracranial Hemorrhage)	2
Alkalosis	2
Fractured Skull	1
Pyloric Stenosis	1
Acrodynia	1
Microcephaly	1
Mongolism	1
Oesophageal Atresia (Pneumonia)	1
Congenital Obliteration of Bile Ducts	1
Erythroblastosis (Intracranial Hemorrhage)	1
Hypoglycemia	1
Acute Atrophy of Liver	1
Subacute Hepatitis	1
Ketosis	1
Morphine Idiosyncrasy	1
Prematurity	1

Chart XI. Miscellaneous conditions precipiating convulsions: 41 cases, 10.2 per cent of total series.

forceps after an easy 18-hour labor. Birth weight was 6-15 and post-natal condition good. At 2½ months, the baby began having several short generalized convulsions each day, but continued to make a fairly satisfactory weight gain. There were no signs of infection except for a transient rhinitis. On the day of entry, the baby had 15 convulsions. The examination was not remarkable except for apathy, apparent blindness although discs were normal, and occasional convulsive episodes. Urinalysis, spinal fluid, blood and spinal Wassermann, and Mantoux 1:1000 all negative. Electrical reactions negative and blood calcium 12.1 mg. Encephalograms revealed slight dilatation of the ventricles and excessive air over the cortex.

The extremely small number of cases, six in all, or 1.5 per cent of the series, labelled as "Questionable Epilepsy", seems at first rather surprising, in view of the frequency with which the diagnosis is made elsewhere. The reasons for the scarcity of cases so labelled in this series are: 1. Idiopathic epilepsy can seldom be diagnosed with accuracy before two years, as chronicity is one of the prime characteristics of the disorder. No doubt many of the infants now listed under "Questionable Etiology", as well as some of those having convulsions in the presence of acute infection, will later develop the classical epileptiform syndrome, as Thom[8] has shown that in a series of 265 unselected cases with infantile convulsions, 29 per cent later developed mental retardation or epilepsy. 2. In our series, practically all cases with unexplained recurrent convulsions were subjected to encephalograms, and the large majority of these were shown to have definite atrophy of the cerebrum, and were so classified.

Plumbism accounted for nine cases, five of them accompanied by encephalitis. Convulsions in this condition were often severe and prolonged, with permanent cerebral damage persisting if the patient survived the acute process. A presumptive diagnosis was made from the history of chewing lead paint, or the use of lead nipple-shields, or the presence of lead pipes in the house; and the etiology was established by the characteristic *X*-rays with the dense lead line at the ends of the long bones, as described by Vogt[9] and others. Less often did the presence of stippling and a lead line in the gums offer corroborative evidence. Treatment was largely symptomatic, and was often quite unsatisfactory, with marked cerebral oedema being found in necropsied cases in spite of massive doses of magnesium sulphate that had been administered intra-muscularly. The most important part of therapeusis is the recognition of the condition, with the removal of the baby from his source of lead, as the condition will correct itself spontaneously with time, unless too marked cerebral damage has already taken place. In babies and children, the administration of drugs such as calcium chloride to effect an acidosis, in order to "de-lead" the patient in a period of quiescence, is fraught with so much danger of precipitating encephalitis, that the procedure is distinctly contra-indicated. No valid explanation can be advanced at present for the infrequent occurrence of plumbism in the Mid-West, as compared to the Atlantic Seaboard, although there is no doubt that we are still overlooking some cases in this state.

Under "Miscellaneous" on Chart XI, we grouped the less common causes of convulsions. Congenital abnormality of the heart accounted for five cases. There were four cases of sinus thrombosis that were verified by autopsy and represent a fairly generalized thrombosis of the cerebral sinuses, and not a terminal event. Congenital syphilis, half with meningitis, accounted for only four cases. An equal number of infants owed their convulsions to subdural hematomas.

There were two cases of alkalosis, both due to the administration of bicarbonate of soda, in one of which the blood CO_2 was reported as 122 volumes per cent. In this instance, a 20-months female infant, because of apathy and vomiting, had been given one tablespoonful of a weak bicarbonate solution every 10 minutes for a period of about eight hours. The baby was moribund at entry with slow irregular shallow respirations, and died as fluids were being given.

The one case of hypoglycemia should be recorded in greater detail.

K. G. was a 16-months old male infant admitted May 23, 1933, with complaints of a convulsion followed by semi-coma. Past history revealed a difficult birth by podalic version and extraction following a long maternal labor. Condition was poor with marked cyanosis for about 36 hours, and one transfusion was given. Course was thereafter uneventful until four months of age, when he had two convulsions following a fall on his right forehead. *X*-rays were negative for fracture, and patient was discharged symptom-free from the surgical service one week later. The story was thereafter not remarkable until two days before entry when the patient vomited once. On the day before entry, the patient vomited twice, developed right-sided convulsive twitching and became semi-comatose. Examination showed a drowsy unresponsive male infant, with evidences of mild rhinitis and pharyngitis, and no neurological signs except for slight nystagmus to the right. Blood sugar at entry was 29 mg.; white count 12,400 with 47 per cent polymorphonuclears; urine negative except for 3+ acetone; Wassermann and Mantoux 1:1000 negative; CO_2 33 volumes per cent; spinal fluid findings were remarkable only in the low sugar level of 29 mg. The patient roused out of his state of semi-coma and appeared much improved following the administration of a 10 per cent dextrose solution intravenously. Glucose tolerance test gave the following readings: 1. Fasting—59 mg.; 30 minutes after dextrose—108 mg.; 60 minutes—77 mg.; 120 minutes—83 mg.; 180 minutes—69 mg. (capillary method).

This was the only case of hypoglycemia found, although blood sugars were taken at entry on most of the atypical babies with convulsions or coma. The past history of presumable birth injury and of trauma at four months makes the diagnosis here less convincing.

Another interesting case was that of a six-weeks old male infant with broncho-pneumonia who exhibited a marked idiosyncrasy to morphia. Following a dosage within pharmacological limits, the baby developed apnoea and cyanosis, and had several short but severe convulsions. Respirations were maintained for over four hours in a Drinker respirator, with the baby eventually recovering.

Several of the other diagnoses included under chart XI obviously represent the primary disease, as proved by operation or autopsy, with secondary or terminal infection directly responsible for the convulsive seizures. The one case of pyloric stenosis may well represent gastric tetany secondary to vomiting, but the diagnosis was not established.

No cases were observed in which enlarged thymus, teething, constipation, worms, or phimosis could be held solely accountable.

SUMMARY

1. Two thousand, two hundred and seventy-nine consecutive records, over a period of 38½ months, in babies under two years of age, were reviewed with the finding of 400 cases that exhibited convulsions immediately prior to, or during their hospital stay, an incidence rate of 17.6 per cent.

2. Acute infection alone accounted for 30 per cent of the convulsions, with pneumonia, the acute upper respiratory disorders, and sepsis being the principal offenders, in order named. The hemolytic streptococcus was responsible for the majority of the septic cases, being closely followed by the pneumococcus and the staphylococcus aureus.

3. Acute intestinal disorder, or alimentary intoxication, accounted for only 2.7 per cent of the total, with convulsions usually an indication of impending death.

4. Acute central nervous system disease contributed 15.5 per cent to the total with meningitis responsible for most of the cases. The influenza bacillus, the pneumococcus, and the tubercle bacillus were the principal etiological agents. Most of the remaining cases in this group were due to acute encephalitis, secondary to lead, to pertussis, and of undetermined origin.

5. Infantile tetany represented 11.3 per cent of the series. In the cases investigated:

(a) Tetany was found to be comparatively frequent in the first four months of life, and uncommon after one year of age.
(b) Rickets was commonly found in the spasmophilic infant, the incidence increasing with the age of the patient.
(c) Similarly, as the infant with latent tetany grew older, acute infection was increasingly apt to be the activating agent.
(d) The highest incidence of tetany occurred at a double peak, in winter and early spring.

6. Cerebral birth injury is responsible for only 8.5 per cent of the entire series, although in the neo-natal period (up to one month of age), it is the chief offender.

7. Intracranial hemorrhage is most often the result of birth injury, but may be due to other conditions, such as hemorrhagic disease of the new-born or erythroblastosis foetalis.

8. Cerebral deficiency was found in 9.5 per cent of the convulsive cases, and was ordinarily the sequela of birth injury, although a few of the cases were known to be post-infectious, post-encephalitic, or developmental.

9. The tentative diagnosis of epilepsy was made in only 1.5 per cent of the series, because of the lack of chronicity in many cases which may later prove truly epileptic, and the fact that encephalograms revealed cerebral deficiency in a large number that might otherwise have been called idiopathic epilepsy.

10. Lead poisoning, often with encephalitis, accounted for 2.3 per cent. The condition is not frequent in the Mid-West, but is probably at times overlooked, because of failure to take an

adequate history and omission of roentgenological studies of the long bones.

11. Among the less frequent causes of convulsions are congenital abnormality of the heart, sinus thrombosis, subdural hematoma, congenital syphilis, and 23 miscellaneous conditions, in several of which the convulsions were terminal accompanying a secondary infection.

12. Bicarbonate of soda may be a dangerous drug as two cases of alkalosis with convulsions occurred in infants to whom it had been administered therapeutically.

13. No cases were observed in which enlarged thymus, teething, constipation, worms, or phimosis could be held solely accountable.

CONCLUSION

Convulsions should always be considered as a symptom-complex of some primary disease, and immediate steps are indicated to determine its etiology in order that appropriate and effective therapy may be carried out.

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DISCUSSION

JOSEPH E. MCCLELLAND, M.D., Cleveland, Ohio: I think that the etiologic factors found responsible in this series would be closely paralleled in a similar series in this vicinity. One is impressed by the difference of causes of convulsions in infancy from those operating in older children.

The important lesson is given in the author's conclusion where he emphasizes the importance of finding the cause of the convulsions if possible rather than simply treating the outstanding symptom.

The idea that many of the convulsions occurring in infants with acute infections are due to a latent spasmophilia has always appealed strongly to me.

While tetany is accompanied by a lowered blood calcium or a low calcium type of rickets, the true cause has never been accurately established. The role of the parathyroids in the control of calcium metabolism furnishes interesting ground for speculation and according to some recent work, these cases respond promptly to early parathyroid therapy.

The cases of acute hemorrhagic pachymeningitis are not so rare in infants under the age of eighteen months and they frequently escape recognition unless one is familiar with the triad of convulsions, bulging fontanelle, and hemorrhages into the eye grounds.

The role of alkalosis as a cause of convulsions must always be born in mind. The indiscriminate dosing of infants with vomiting spells with bicarbonate of soda is to be condemned.

Finally in all cases of cerebral birth injury, hydrocephalus, microcephaly and epilepsy, the importance of information which can be got only through the use of encephalography must be remembered. The information gained in this way is often quite enlightening and gratifying to distressed parents.

M. M. MILLER, M.D., Akron, Ohio: Dr. Brown's paper is an excellent resumé of the etiology of convulsions and it emphasizes the importance and complexities of differential diagnosis. He confirms the common experience that acute infection is the commonest cause or at least the most frequent "trigger mechanism".

There are many cases of spasmophilia which never show convulsions without the added insult of acute infection. On the other hand, there are many infants who do not have spasmophilia but whose nervous systems are inherently so unstable that they react characteristically with convulsions to any febrile disease. In both types convulsions associated with upper respiratory infections are exceedingly common and probably comprise the majority of cases we are called upon to treat in the home. Infections of the central nervous system comprise the next largest group (62 cases in the author's series). In my experience another infection often associated with convulsions has been enteritis. Dr. Brown's list of miscellaneous causes did not include any cases due to uremia and to strychnine poisoning. His one case of convulsions due to poliomyelitis might give a wrong impression of the true incidence of this symptom, for certain epidemics of poliomyelitis show a much greater incidence of cerebral involvement than others and in the polio-encephalitic type convulsions are common.

Meningismus without convulsions I have observed more frequently in early lobar pneumonia than in any other disease.

When confronted with a case of chronic convulsions of obscure etiology the physician's first thought is of epilepsy, but this should be the last thing considered in the differential diagnosis. No child should be stigmatized with a diagnosis of epilepsy until all other possible factors have been eliminated. It is extremely helpful to sit down and write a list of all the possible causes one can think of in such cases. By no means a complete list of conditions to be considered would include cerebral hemorrhage from birth injury, skull fracture, brain tumor, tuberculoma, pachymeningitis, chronic encephalitis and meningitis, syphilis, spasmophilia, hypoglycemia, digestive disturbances, intestinal parasites, chronic focal infection, masturbation, phimosis and finally, epilepsy. Many of these conditions can be ruled out at once; others will require careful study. I saw a case in point four years ago in a well developed boy of two years, who had been having frequent convulsions daily for weeks and which strongly suggested epilepsy. Differential study ruled out everything but chronically infected tonsils, phimosis and epilepsy. The child then had a circumcision and T. and A. and has never had another convulsion. Had he continued to have convulsions I should then, and not till then, have been satisfied with a diagnosis of epilepsy.

THYROID FACTOR IN MENTAL DISEASE

By N. W. KAISER, M.D., Toledo, Ohio

THE official classification of mental diseases recognizes the existence of psychoses due to disorders of thyroid function and places them under the group of psychoses with somatic disease. These disorders of the thyroid gland have been variously classified, the classification at times being somewhat confusing. The function of the thyroid gland is to secrete thyroxin in quantities sufficient for and consistent with normal metabolism and health. If for any reason the secretion of the thyroid becomes disordered, either physical or mental changes may result and sometimes both.

Two or possibly three disorders may exist in connection with thyroid function. First, there may be a diminished secretion; second, there may be an increased, and third, there is a possibility of a perverted or toxic secretion where the structure of the thyroxin molecule has been altered. When conditions of hypo, hyper, or toxic secretions exist, there are frequently more or less well defined clinical symptoms, but when a psychotic individual is encountered with clinical manifestations of thyroid disorder, a problem is at once presented and that problem is to determine whether or not the thyroid disorder is a primary etiological factor in the production of the psychosis or whether it is merely a complication, or whether the clinical manifestations in evidence may be the result of autonomic nervous system imbalance in which an emotional factor such as fear, anxiety, or apprehension has been of important etiological significance.

The following remarks will be limited largely to a discussion of psychotic persons whose clinical manifestations have at least suggested the probability of a thyrotoxicosis.

In goitrous districts, such as exist in at least part of the Toledo State Hospital territory, a rather high percentage of patients admitted to the hospital have been found to show clinical evidence of toxic thyroids. It is often a difficult problem, however, to determine the significance of the thyroid factor in its relation to the psychosis. Experience has taught us that mistakes in diagnoses are quite possible.

CASE REPORTS

For example, in the summer of 1931, a male patient in his early 30's was admitted to the hospital presenting a typical picture of Graves' disease. His weight was 89 lbs. The mental symptoms were those of an extreme, agitated depression, accompanied by morbid fears, delusions, and definite suicidal inclinations. Metabolic rate was plus 35. History and clinical features of the case were such that the medical staff unanimously agreed upon a diagnosis of psychosis due to exophthalmic goitre. Thyroidectomy was carried out on August 12, 1931. Following operation, the patient made a slow, but progressive improvement. In the course of four months he gained about 25 pounds. He was released from the hospital much improved physically and apparently free from any evidence of mental aberration. In this particular case it was felt at the time that the correct diagnosis had been made and that appropriate treatment had been instituted, but before many months had elapsed, he developed a typical picture of the elated manic phase of manic depressive psychosis and was returned to the hospital. Since that time he has had several recurrences of his psychosis. Some months ago he was transferred to a Veterans' Bureau hospital. Although this man originally presented a picture strongly suggesting a psychosis due to thyrotoxicosis, yet the subsequent developments in the case undoubtedly established the fact that he was suffering from Graves' disease, but that his psychosis was primarily manic depressive in character.

Another illustration of a somewhat different situation is as follows:

In 1928, a middle-aged woman presented herself to the writer for examination at the outpatient department of the hospital. She was negotiating the sale of some property and stated that the validity of her signature had been questioned due to the fact that she had previously been a patient at the Toledo State Hospital. She had been referred to the clinic for psychiatric examination. Such examination failed to reveal any evidence of mental disorder. Briefly her history is as follows: In 1917 she had been committed to the Toledo State Hospital and diagnosed as involution melancholia. She remained in the hospital continuously for seven years and then escaped in 1924. She went to Hamilton, Ontario, Canada, and in that city had a goitre removed, following which she felt that she had completely recovered from her mental illness.

She apparently had remained well for four years. Contact with the hospital and physician in Canada confirmed the information which the patient gave relative to her thyroidectomy. She made the following statement, "If my goitre had been removed in 1917, I do not think it would have been necessary for me to have been in the State Hospital for seven years." It is quite possible that she was correct in this statement.

During the summer of 1931, a woman in her early 40's (S.T.) was admitted to the hospital presenting a very typical picture of exophthalmic goitre, accompanied by an extreme emotional depression and rather definite suicidal tendencies. She was diagnosed as psychosis due to exophthalmic goitre. Thyroidectomy was performed on July 7, 1931. In the course of a few weeks her mental status had returned to normal and in three months' time she had gained 30 pounds and apparently was free from thyrotoxic symptoms. She was discharged as recovered in Dec., 1931, and so far as can be learned has remained well up to the present time. It would appear that in

Read before the Section on Nervous and Mental Diseases, Ohio State Medical Association, at the 88th Annual Meeting, Columbus, October 4-6, 1934.

TABLE 1.

New Admissions of Nine Psychotic Groups For Years 1930-1931-1932 Examined for Evidence of Thyrotoxicosis

Psychoses Classification	Total Admissions	Total of Thyrotoxic Suspects. Findings either vague or definite	Definite Thyrotoxic Cases. Thyroidectomy advised	Number Operated
Psychoses With Somatic Disease	106	13 or 12%	9 or 8%	3
Manic Depressive Psychoses	352	39 or 11%	25 or 7%	3
Involution Melancholia	48	4 or 8%	1 or 2%	
Dementia Praecox	240	40 or 17%	18 or 17.5%	3
Paranoia And Paranoid Condition	45	11 or 24%	3 or 7%	
Psychoneuroses	37	2 or 5%	1 or 3%	
Psychoses With Psychopathic Personality	19	3 or 16%	2 or 10%	
Psychoses With Mental Deficiency	63	6 or 10%	6 or 10%	
Undiagnosed Psychoses	22	5 or 23%	2 or 9%	1
TOTAL	932	123 or 13%	67 or 7%	

this case the correct diagnosis was made and that her recovery was more or less directly due to the removal of her goitre.

Other instances might be mentioned which would indicate that psychoses may develop following thyroidectomy.

For example, in December, 1925, a woman, 29 years of age, was admitted to the hospital with a history of having had a thyroidectomy about one year prior to her admission. Two days following operation, she became confused, delirious and developed some unsystematized delusions. For approximately a year she was cared for either at home or in private sanitariums. Her psychosis, however, continued and on her admission to the hospital she presented a rather typical picture of dementia praecox, of the hebephrenic type. Her case records state that she was hallucinated, incoherent, impulsive, expressed numerous grotesque delusions. Her emotional attitude was entirely inadequate. She showed a decided loss of affect and general lack of interest. A few weeks following admission she was given thyroid extract. Her condition showed a gradual improvement and three months later she was released from the hospital very much improved.

Thyroid medication was continued at her home and in June, 1926, she had completely recovered and was discharged from the hospital. Reports received concerning this case only a few weeks ago indicate that she has remained entirely well in every respect since the date of her discharge eight years ago. Of the many physicians who had had contact with this patient during her period of illness, several expressed themselves as being of the opinion that her psychosis was precipitated by thyroidectomy and probably would not have occurred had that surgical procedure been avoided.

Another woman 48 years of age, who had never had any previous mental disorder, developed an acute psychosis three weeks following thyroidectomy. She was cared for in general hospitals for about three months and then admitted to the Toledo State Hospital in July, 1928. On admission she was in an extremely emaciated condition, weighing only 70 pounds. Her mental picture was that of a severe type of acute confusional insanity. She was given thyroid extract for some time, but showed little or no response to treatment. Parathyroid extract treatment was later instituted followed by rather definite improvement. After having been hospitalized for about seven months, she had recovered to the extent that she was released on trial visit. Her improvement continued at home and she was finally discharged as recovered and has now remained completely well for a period of more than five years.

These cases illustrate three different types of psychotic problems apparently associated with a thyroid factor. In two of the cases outlined the psychosis could evidently be attributed to a thyrotoxicosis. In two other cases an extremely severe and prolonged mental aberration was apparently precipitated by thyroidectomy. In one case a severe degree of Graves' disease existed as a complication of a manic depressive psychosis.

While such instances as these present definite problems in diagnoses, there is, however, another type of case in which the problem is still more complex. We refer to those individuals who as a result of autonomic imbalance of emotional tension present clinical symptoms suggesting a thyrotoxicosis. In these cases, we frequently find tachycardia, tremors, palpitation, lose of weight, excessive moisture of the skin and even an increased metabolic rate.

The thyroid gland, however, is not primarily involved.

TABLE 2.

Results in Fifty-seven Psychotic Patients All Showing Definite Evidence of Thyrotoxicosis, but Not Operated.

First Admissions For Years 1930-1931-1932

Mental Diagnoses	Total Admissions	Toxic Thyroids	Present Status Sept. 1934 Recovered	Improved	Unimproved	Dead
Psychoses With Somatic Disease	106	6	2	1	2	1
Manic Depressive Psychoses	352	22	7	4	8	3
Involution Melancholia	48	1			1	
Dementia Praecox	240	15	2	5	7	1
Paranoia and Paranoid Condition	45	3			3	
Psychoneuroses	37	1	1			
Psychoses With Psychopathic Personality	19	2	2			
Psychoses With Mental Deficiency	63	6	4	1	1	
Undiagnosed Psychoses	22	1			1	
Total	932	57	18	11	23	5
Per cent Totals			31%	19%	40%	9%

In fifty-seven thyrotoxic patients who were not operated, results are as follows:

31% Recovered
19% Improved
40% Unimproved
9% Dead

As an illustration, a man 33 years of age was recently admitted to the hospital. The physicians who certified his commitment stated that he was a well marked case of hyperthyroidism, with rapid pulse, tremor, palpitation, etc., and in the commitment certificate recommended thyroidectomy. On examination subsequent to admission, the pulse rate on several occasions was below 80. There was no tremor, only a very slight thyroid enlargement and in general there were no symptoms which would definitely indicate a Graves' disease. Mental examination, however, showed numerous paranoid projections associated with a decided emotional tension and when his emotional complex was approached tachycardia, tremor and excessive perspiration was frequently exhibited.

Another young man was recently admitted to the hospital who had developed an acute psychosis a few weeks after being married. An emotional instability was one of the outstanding psychotic symptoms. There was a slight thyroid enlargement, extreme restlessness, rapid pulse, at times considerable tremor and his clinical condition in general suggested a thyroid picture. In this case, however, a history of a definite mother fixation was obtained which upon his marriage apparently precipitated a mental conflict, resulting in a definite psychosis. After a few weeks of treatment, he made a good recovery and his apparent thyrotoxic symptoms entirely disappeared.

The physician who has an opportunity to observe all the variations of mental aberration is familiar with the tachycardias, the tremors, the restless activities, the dilated pupils and even the increased metabolic rates which frequently exist in states of emotional tension. In these conditions clinical symptoms are frequently in evidence which would suggest thyroid disorder. Actually, however, these symptoms are of psychic origin. The importance of this psychic factor is often underestimated. Stoddard[1] has drawn attention to the fact that "the physical signs of exophthalmic goitre, with the exception of the exophthalmos, are almost identical with the symptoms manifested by normal persons experiencing the emotion of fear. Pottenger[2] in discussing the normal and abnormal action of body cells, draws attention to the fact that emotional and psychic stimuli influence cellular action the same as physical stimuli.

Importance of reckoning with the psychic state in pathologic studies should be evident when we recall that every function in life has a psychic bearing. Hence, the correct interpretation and evaluation of the toxic thyroid factor in mental disease frequently presents a very complex problem.

Textbooks on psychiatry do not devote much space to the discussion of the subject. White[3] mentions the exophthalmic type of goitre and states that "the prevailing mental tone associated with this disease is fear and apprehension and is at times associated with visual and auditory hal-

TABLE 3.

RESULTS FOLLOWING THYROIDECTOMY IN 10 PSYCHOTIC PATIENTS

All Patients Admitted and Operated During Years 1930-1931-1932.

Number	Name	Sex	Mental Diagnosis	Operation Date	Status Sept. 1934	
12238	J.M.	M	Psychosis With Somatic Disease	6-7-30	Recovered	Discharged 10-31-32
9893	S.F.	F	Psychosis With Somatic Disease	7-7-31	Recovered	Discharged 12-18-31
9639	J.G.	F	Psychosis With Somatic Disease	7-28-30	Dead	Suicided 9-28-30
12792	R.G.	M	Manic Depressive Psychosis, Depressed Type	8-12-31	Improved	Discharged 1-6-34
9343	H.L.	F	Manic Depressive Psychosis, Depressed Type	7-28-30	Recovered	In Hospital
10300	F.E.	F	Manic Depressive Psychosis, Manic Type	3-31-31	Improved	Trial Visit 6-3-33
10020	M.B.	F	Dementia Praecox, Hebephrenic Type	1-9-32	Recovered	Discharged 5-31-34
9068	A.M.	F	Dementia Praecox, Hebephrenic Type	6-21-30	Improved	Discharged 12-31-30
13071	F.S.	M	Dementia Praecox, Paranoid Type	9-6-32	Unimproved	In Hospital
8816	C.B.	F	Undiagnosed Psychosis	6-10-30	Recovered	Trial Visit 9-1-34

Recovered 50%
Improved 30%
Unimproved 10%
Dead 10%

lucinations." He also mentions the occasional acute deliriums following thyroidectomy.

Bleuller's[4] discussion is somewhat more complete. Quotation as follows: "Basedow's disease is not rarely accompanied by psychoses. These psychoses, however, have no uniform picture. Hysterias often accompany the disease and present syndromes similar to neurasthenia. One also observes depression with anxiety states and milder forms of mania. Most frequently, however, one finds pronounced chronic states similar to catatonia with marked excitement, dissociation of thoughts, confused and sometimes symbolized delusions, hallucinations of hearing, sight, taste and smell. Neither in the description nor in the few cases that I have seen myself can I distinguish them absolutely from catatonic states as the difference consists only in the absence of a pronounced schizophrenic coloring. The activity remains livelier, the stream of thought is not so disconnected and catatonic symptoms are rare or not so pronounced."

Stoddart[5] discusses myxedema and cretinism as mental disorders associated with primary disease of endocrine glands, but considers exophthalmic goitre as a type of psychoneurosis classifying it as a variety of anxiety hysteria, with protrusion of the eye-balls and enlargement of the thyroid superadded. In his opinion the etiological factor is a partial or complete repression of fear, which finds expression in the symptoms of exophthalmic goitre.

Noyes[6] describes the mental symptoms associated with toxic thyroids as restlessness, excitability, irritability, with the occasional development of more serious symptoms such as depression and apprehension.

One of the major problems presented in connection with toxic thyroids in psychotic persons is to determine the etiological significance of the thyroid in its relation to the psychosis. It would seem that no clear cut or specific rules can be laid down to solve this diagnostic problem. A diagnosis due to thyrotoxicosis should not be made unless the possibility of the existence of any other type of psychosis can be ruled out. It may be appropriate here to refer to the suggestion of Blueller[3] that "Thyrotoxic cases although they present no uniform mental picture, yet they may simulate the praecox or the manic, but differ from these psychoses only by the absence of a pronounced manic or schizophrenic coloring". Possibly one differential diagnostic feature in the true thyrotoxic psychosis is the fact that at least some of these cases have a fairly keen insight concerning their mental aberration, whereas in the frank psychosis, such as the praecoxes and manics, this insight is usually lacking.

The question arises as to what therapeutic measures should be instituted in connection with

TABLE 4.

Comparative Findings in Three Groups of Patients
All Selected From Nine Psychotic Types* Admitted During 1930-1931-1932.
Group A—865—Non-thyrotoxic Patients
Group B— 57—Thyrotoxic Patients Not Operated
Group C— 10—Thyrotoxic Patients Operated

Group	Total Admissions	Status September, 1934 Recovered	Improved	Unimproved or Dead
A. Non-thyrotoxic Patients	865	384 or 44%	238 or 27%	243 or 28%
B. Thyrotoxicoses—Not Operated	57	18 or 31%	11 or 19%	28 or 49%
C. Thyrotoxicoses—Operated	10	5 or 50%	3 or 30%	2 or 20%
	932	407 or 43%	252 or 27%	273 or 29%

* Psychoses With Somatic Disease
Manic Depressive Psychoses
Involution Melancholia
Dementia Praecox
Paranoia and Paranoid Conditions
Psychoneuroses
Psychoses with Psychopathic Personality
Psychoses with Mental Deficiency
Undiagnosed Psychoses

these patients. In those cases where the thyrotoxic origin of the psychosis can be more or less definitely established, surgical treatment is undoubtedly the most effective therapeutic procedure. The question of thyroidectomy in the manics, praecoxes and other psychoses is a subject which is well worthy of discussion. It would seem that the existence of a psychosis, for instance, in a manic or a praecox would tend to retard rather than favor recovery. Although a conservative attitude should be adopted in recommending thyroidectomy, yet on the other hand there does not appear to be any substantial reason why a psychotic individual should not be permitted to receive the benefit of surgical treatment when a toxic thyroid exists as a complication of a psychosis.

While the more acute thyroid intoxications may give rise to delirious states, marked by extreme excitement, accompanied by sleeplessness, incoherence and hallucinations, it would seem from the above discussion that psychoses due to thyrotoxicosis may easily be confused with the manic depressive psychoses, the psychoneuroses or even the schizophrenias.

Recognizing the prevalence of goitre and the frequency of symptoms characteristic of thyrotoxicosis in patients admitted to the Toledo State Hospital, a diagnostic clinic was established in 1930 and placed under the direction of a consulting endocrinologist. One of the purposes of this clinic was to determine the frequency of thyrotoxicoses and to more correctly evaluate the significance of such disorders in their relation to mental disease. Patients referred to this clinic were selected largely from new admissions, except the seniles, the paretics, the organic diseases of the brain, and such cases where the psychosis was obviously due to some cause not in any way related to the thyroid gland.

The following report will be limited to discussion of thyroid disorders and will deal with the thyrotoxic suspects found in new admissions for a period of three years, 1930-31-32. During this three-year period a total of 932 patients were examined from nine psychotic groups (See Table No. 1). One hundred and twenty-three or 13 per cent were found to show either vague or definite symptoms of thyrotoxicosis. In 67, or 7 per cent, the symptoms of thyrotoxicosis were definite and thyroidectomy was advised. It was found that out of the 932 patients examined, 865 were apparently free from toxic thyroid symptoms. Only ten of the 67 cases recommended for thyroidectomy were actually operated. A check up at the present time shows that 50 per cent of these are recovered, 30 per cent improved, 10 per cent unimproved, and 10 per cent dead. In the 865 non-toxic thyroid patients, 44 per cent are recovered, 27 per cent improved and 28 per cent dead or unimproved. In the 57 thyrotoxic patients who were not operated, 31 per cent are recovered, 19 per cent are improved and 49 per cent dead or unimproved.

The accompanying tables will show the frequency of thyrotoxic findings in the different psychotic groups. In the total group of 932 patients, 7 per cent showed definite evidence of thyrotoxicosis, and an additional 6 per cent showed suggestive findings. It is of interest to compare these findings with a Toledo surgeon[7] who reports that in 250 cases of toxic goitre in his private practice, 6 per cent showed definite mental symptoms.

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PREVENTION AND TREATMENT OF DIPHTHERIA

By H. H. PANSING, M.D., Dayton, Ohio

IT IS not the purpose of this paper to discuss at length the very fine work that has been done in Ohio and elsewhere in the prevention of diphtheria, or to minimize the very excellent results that have been accomplished in the reduction of the death rate, but mainly to point out and emphasize the so-called little things and yet very important attributes that may aid in the prevention of many deaths that are still caused each year by diphtheria.

Thirty-five years ago before we knew any of the modern methods of control and prevention of diphtheria, this disease was rightly considered the most dreaded and destructive disease of childhood. An outbreak of diphtheria always aroused great fear among the people generally, and well it might, for there are records of many instances where all the children of a family were destroyed by it. Parents, health officials and physicians stood helpless in the face of such an outbreak because the medical knowledge at that time did not provide them with efficient means of combating this scourge. Thanks to medical science, there are now few diseases that we know more about than diphtheria. Its cause is well understood and means of prevention have been thoroughly worked out.

For many years prior to 1895, diphtheria held front rank among the principal causes of death. From 40 to 70 per cent of the cases of diphtheria died, causing death rates which varied from 100 to 200 per hundred thousand population. In 1896, the death rate began to fall and by 1920, it had been reduced to comparatively secondary importance as a cause of death. For this encouraging result, we are indebted to laboratory workers and physicians who have put into practical application the discoveries of Von Behring, Roux, and other scientists who first developed diphtheria antitoxin. The year 1895 is an important date in the history of diphtheria because it was in that year that the general distribution of diphtheria antitoxin began. From that time on, the increasing use of diphtheria antitoxin was paralleled by a remarkable drop in the death rate, so that from previous rates as high as 200 per hundred thousand, it fell to 46 in 1899, 29 in 1914 and to about 15 in 1920.

In 1913, it was Von Behring, who again demonstrated the possibility of protecting children and adults against diphtheria by treating them with a mixture of diphtheria toxin and diphtheria antitoxin commonly called toxin-antitoxin. Records prove that in many campaigns this method of immunization against diphtheria is not dangerous and is certainly effective. Later on we learned of diphtheria toxoid, based upon the experimental work done by Glenny and Hopkins, in England, who in 1921, reported that by clinical means diphtheria toxin could be so modified that its toxicity was abolished while its power to induce active immunity was retained.

The results from toxoid in general have been quite favorable. Doctor W. H. Park of New York and the late Doctor Zingher found that from 88 to 98 per cent of the children gave a negative Schick test two or three months after treatment. There being no serum in toxoid, it cannot sensitize a person to any antitoxin or serum. It is more stable, it is not easily affected by changes in temperature, is non-toxic and in equivalent doses will immunize a higher percentage of persons with less time to induce immunity after injections and with less reaction.

In 1923, a pamphlet was prepared by the Division of Communicable Diseases of the Ohio Department of Health upon diphtheria and how it is prevented. This slogan was adopted, "No Child in Ohio need die of Diphtheria." Much excellent work has been done, and yet, in the period covering the ten years between 1924 and the beginning of 1934, Doctor Van Orsdall reported a total of 44,415 cases of diphtheria, with a total of 3127 deaths. The highest number of cases was in 1926 and '27, showing a rate of 103.3 and 109.4 per 100,000 population and a death rate of 7.51 and 7.79. In 1933, 2362 cases were reported showing a case rate of 34.03, and 164 deaths with a death rate of 2.36. This is ample proof that more intensive work could be done.

Natural Immunity—Statistics prove that about 85 per cent of all babies from birth to six or nine months of age are protected from diphtheria by antitoxin which they have received from the mother before birth and in mother's milk after birth. This natural antitoxin which protects so many babies disappears at six to nine months of age and the average child has no further protection until six to nine years and later, when he begins to develop his own antitoxin. Between the ages of six to nine months and six to nine years, children are most susceptible and nearly all the deaths from diphtheria occur among children of these ages. If we could prevent diphtheria deaths in children between these ages, we would reduce the diphtheria deaths in Ohio by more than 80 per cent. Between the ages of 15 and 45 years of age, it seems that the degree of susceptibility is least, again increasing after that age.

One attack does not render immunity, as proved

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by Reiche, in Hamburg, that 5.8 per cent of 4761 cases, were known to have had a previous attack. Doctor Park in his recent pamphlet says a preliminary Schick test to estimate susceptibility is not done in infants or even in children up to three years of age, as up to that time the great majority are susceptible. It is advisable but not necessary to give older children and adults a preliminary Schick test before giving them toxoid. At these ages at least half of them are already immune and therefore do not need an injection of toxoid. However, as it is harmless, it may be simpler to give all of them the toxoid without the Schick test. It is always advisable when practical to do a Schick test from three to six months after immunization because even with toxoid a very small per cent remains susceptible.

It has been our experience that rural children especially, are highly susceptible to diphtheria. Our previous Schick tests have shown that from 90 to 95 per cent of the children in our county (Montgomery) are positive. With three doses of toxin-antitoxin given to those that were Shicked positive in a series of 5000 children, we found on re-Schicking that we had immunized 71 per cent while in some cities they reported as high as 90 to 95 per cent. This left a possible 29 per cent not immunized.

Omitting the first Schick because of the high degree of susceptibility and giving four doses of toxin-antitoxin instead of three and waiting from six months to one year before Schick testing, we found 98½ per cent negative. This method was followed for three years and gave the same results. With two doses of toxoid reports show a number immunized slightly above those given three doses of toxin-antitoxin.

With one dose of toxoid (alum precipitated), we are submitting the following reports:

Diphtheria Immunization—One dose toxoid (alum precipitated). Work done in ten schools, first three grades, all children were Schicked in beginning to determine degree of susceptibility.

A. September 13, 1933, Schicked 527 children.

September 18, 1933, read, and positive ones treated.

Results:

468 positive or 91.2.
45 negative or 8.8 (22 not treated before and 23 previously treated).
14 absent for reading.

B. October 16, 1933—28 days after the toxoid was given we re-Schicked.

462 children with following results:

388 negative or 84 per cent.
74 positive or 16 per cent.

C. Carrying through our original group, these 74 were Schicked the third time at the end of 60 days, to determine if any increase in number of children immunized, over the 28-day period.

Results:

December 8, 1933—55 positive, 7 negative, 5 absent for reading, 7 not reached.

D. Results: Only seven changed from positive to negative at the end of 60 days, out of 67 retested (5 absent for reading).

E. Conclusions:

1. It would seem that the early immunization secured with toxoid would be a distinct advantage over toxin-antitoxin.

2. To secure practically 100 per cent immunization, it would require four doses of toxin-antitoxin, three doses of the two-dose toxoid and two doses of the one-dose toxoid.

3. That as many are immunized at the end of a 30-day period as there would be at the end of a 60-day period, which possibly would indicate that toxoid might help in controlling an epidemic.

F. In a group of 66 children with previous immunity unknown, but treated with one dose toxoid, gave the following results:

59 negative or 89.3 per cent.
7 positive or 10.7 per cent.

This would prove that in order to arrive at a definite conclusion as to comparative results obtained from either method, immunity should first be determined by Schick testing the entire group before beginning with the immunization, and might explain why some districts report a higher percentage of immunization.

Diphtheria Immunization—one dose toxoid (alum precipitated). Five schools—first three grades.

A. First Schick to determine degree of susceptibility.

Jan. 23, 1934—Schicked 570 children.

Jan. 29, 1934—Read results of first Schick.

1. 495 positive; 58 negative; 17 absent for reading.

2. Positive—90 per cent.
Negative—10 per cent.
Part of negatives had previous treatment.

B. Second Schick.

April 4, 1934—65 days after treatment was given 445 children were re-Schicked.

April 9, 1934—we read 423.

1. 363 negative; 60 positive; and 22 absent.

2. Negative—85.8 per cent—86 per cent.
Positive—14.2 per cent—14 per cent.

In different schools:

1. Englewood—83 per cent susceptible, 17 not.
After toxoid—93 1/3 per cent negative, 6 2/3 per cent positive.

2. Trotwood—90.7 per cent susceptible, 9.3 per cent not.
After toxoid—88 per cent negative, 12 per cent positive.

3. Brookville—96 per cent susceptible, 4 per cent not.

   After toxoid—96.5 per cent negative, 3½ per cent positive.

4. Johnsville-New Lebanon—94 4/9 per cent susceptible, 5 5/9 per cent not.
   After toxoid—83 per cent negative, 17 per cent positive.

5. Miamisburg—87 per cent susceptible; 13 per cent not.
   After toxoid—79 per cent negative, 21 per cent positive.

TREATMENT OF DIPHTHERIA CASES

It need not be said that in diphtheria, an early diagnosis is very important, since so much depends upon the early administration of antitoxin. The diagnosis often rests upon a combination of clinical symptoms and laboratory findings. Positive cultures alone do not necessarily mean clinical diphtheria, even though sore throat and fever are present. Cases of streptococcal tonsillitis, with follicular patches resembling false membrane, occur in diphtheria bacillus carriers. Such persons give negative Schick reactions and do not have clinical diphtheria despite the positive findings in cultures taken from their throats. It is important to remember that the diagnosis of clinical diphtheria cannot be made in the laboratory as a result of finding virulent diphtheria bacilli in cultures. Cultures should be taken of all sore throats in order to exclude or confirm diphtheria.

ANTITOXIN AND HOW ADMINISTERED TO GET BEST RESULTS

Always give antitoxin in a clinical case of diphtheria without waiting for laboratory confirmation of the diagnosis. It is inexcusable to delay or hesitate to use full doses of antitoxin in diphtheria. However, to give antitoxin to a diphtheria carrier or one already immunized would be useless. It is most interesting to note that in general practice few physicians seem to agree upon the time of administration, the amount of antitoxin administered and the method of administration. It would seem that every physician should insist upon giving a reasonably large dose of antitoxin early, according to age and size of a patient, especially if it be a child, intramuscularly or intravenously to promote more rapid absorption in order to secure the best result.

An analysis of the report of deaths in our own state will prove the truth of the above statement. In 751 deaths due to diphtheria, 252 of these cases did not call the physician until after the third day and the report shows that antitoxin was given to 360 the same day, 134 the second day, 74 the third day, 96 cases did not receive antitoxin until after the fourth day and 76 cases received no antitoxin at all. Since very little is found in our medical literature concerning these vital points, it would seem that some way might be devised for the dissemination of these facts to the physicians. In this I believe all physicians would welcome the services of an up-to-date health department and accept the invitation to use the health commissioner whenever needed.

CONCLUSION

In conclusion, I would say our present knowledge should assist much in the further prevention and treatment of diphtheria. If the parents are educated to call a physician early, if the physician realizes the importance of an early diagnosis and gives a large dose of antitoxin, say from 10,000 to 40,000 units, immediately, it will help much in the reduction of our present death rate from diphtheria. Health departments must also realize that if they will further prevent diphtheria deaths, the children must be immunized long before they reach the school age. This procedure, besides being more efficient, would no doubt produce quite a saving in the expenditure for antitoxin. Laryngeal cases, especially, and all other serious cases should be hospitalized so aspiration and intubation could be resorted to if needed. But until all infants are immunized by their family physician, at the very earliest age that they be found susceptible, then and not before will our slogan, "No Child need die from Diphtheria," be fully realized.

Reibold Building.

DISCUSSION

E. G. HORTON, M.D., Columbus: I would prefer not to speak on this subject from the standpoint of a pediatrician only, as requested, but rather from the all round standpoint of one who has also viewed the subject as a bacteriological laboratory worker, an employe of the Ohio State Board of Health, a member of a county board of health, a health commissioner of a large city, a teacher of the subject for many years in medical colleges, a practicing physician treating cases of diphtheria, a consultant, and spending considerable time for a number of years in service at the Isolation Hospital at Ohio State University.

With all we know and could put into effect, diphtheria should have been entirely blotted out of the State of Ohio, yet the fact remains the problem has not been solved. Part of the fault rests with the ignorance and indifference of family heads, and part with indifferent physicians. Both physicians and families need to be better sold on the subject, and should be hypodermically or otherwise inoculated with both activity and a sense of responsibility. It is frankly my feeling that social workers and in some cases boards of health have in their enthusiasm erred in the better ways of procedures, and instead of cooperating with the medical profession have tended to widen the gap, thus failing to have attained the greater results that might have been attained. Physicians also have not measured up to their possibilities. And the little children of dependent age are paying the penalty with their lives. Most families will pay more attention to what the family physician says than to what anyone else says whether an official or an individual. Immunization can be best carried on through a closer cooperation with the medical profession.

PRACTICAL OPHTHALMOSCOPY

By W. C. DAVIS, M.D., Columbus, Ohio

IT IS the hope of the writer that this paper may be of interest and of some value to physicians who are more or less interested in the general practice of medicine.

Years ago the physician would usually approach the patient's bedside, take a look at the patient's tongue, feel of his pulse, place an ear over his heart, thump over his chest and abdomen, ask a few questions and then prescribe, trusting to Providence that the correct diagnosis had been made and that the treatment would be successful.

Since that time many changes have taken place. The thermometer put in an appearance and the stethoscope, laboratory apparatus, *X*-rays, fluoroscope and many other instruments for the more accurate diagnosis of diseases have come into constant general use.

Among these various instruments and by no means the least in importance is the ophthalmoscope. This instrument, as you no doubt know, is made up of a number of lenses, of different strength, arranged on dials so that any strength lens desired can be rotated in front of the sight hole through which the eye is to be examined.

A mirror is so placed on the front of the instrument that a light from behind the patient can be reflected into the eye to be examined, illuminating the interior of it for inspection by the observer.

Ophthalmoscopy is the science and art of examining the interior of the eye by means of an ophthalmoscope.

The ophthalmoscope was invented in 1851 by von Helmholtz, since which time it has been perfected in many ways. Ever since it was first presented to the medical profession it has been much used by ophthalmologists but only recently has it been taken up, to any extent, by the general practitioner. I venture to predict that sooner or later it will be as indispensable as the thermometer or stethoscope and will be found in the armamentarium of every up-to-date physician.

It is not difficult, but takes much practice, to use the instrument satisfactorily.

Preparatory to examination it is well to have a somewhat dilated pupil, otherwise it is difficult to obtain any conception of the conditions existing within the eye. Ordinarily a very satisfactory dilatation can be secured by the use of a few drops of 2 per cent euphthalmine, the effect of which can be very speedily gotten rid of by the follow-up use of eserine or pilocarpine. Euphthalmine has very little effect on the accommodation, lasts only a short time and therefore gives the patient very little annoyance.

We are warned never to use a mydriatic in a case in whom we feel there is the least tendency to increase of intra-ocular tension for fear that an acute glaucoma might be brought on. Fortunately in these cases the pupil is already usually sufficiently dilated for our purpose. Another argument is that it might be well to cause a flare-up at a time when the patient is under observation and can immediately have the condition cared for; however I think it is taking considerable unnecessary risk.

In order to recognize a diseased or abnormal condition it is necessary to be familiar with the normal. There is a wide variation in appearance of normal or non-pathological fundae—no two of which are exactly alike. They are as varied as faces and just as interesting to study.

I think when I first began using the instrument I was absolutely certain that every eye I looked into was diseased, just as, when I first began the practice of medicine, every obstetrical case I had, for quite a few cases, I was absolutely certain was a real post-partum hemorrhage and yet not one single case of post-partum hemorrhage did I ever have.

The examiner should have fairly good vision and if he has any considerable error of refraction he should wear his correction while making an examination.

Two kinds of ophthalmoscopes are to be had: those reflecting light by means of a mirror and the electric ones transmitting the light directly into the eye. One of the simplest and most satisfactory instruments is the Loring which I think is the one that most of us started out with.

In talking about ophthalmoscopy we must mention the difference between the direct and the indirect methods—the former giving a much more magnified image but a more restricted field.

Size of the image in the direct method is about seventeen times the size of the normal and in the indirect method about four or five times the size of the normal.

The direct method necessitates the instrument being held close to the observer's eye and then brought as close to the observed eye as possible, the observer getting an upright image of the contents of the observed eye.

The indirect method makes it necessary for the instrument to be held close to the observer's eye and fifteen or eighteen inches away from the observed eye and a strong magnifying lens held three or four inches in front of the observed eye.

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This method gives an upside down image of the fundus of the eye.

It is claimed by some that when an electric ophthalmoscope is used a dark room is not necessary but it has been my experience that far more satisfactory results are obtained in a fairly dark room, the darker the better.

Position of the patient has something to do with results. With the patient upright, best results are obtained. If the patient is bedfast and cannot be elevated completely, I think best results can be had with the patient entirely flat.

For indirect ophthalmoscopy I much prefer the plain ophthalmoscope with a bright steady light on a level with and back of the patient's head and even for direct opththalmoscopy it is very satisfactory. However, this is not feasible for bedside work, therefore for general work the electric ophthalmoscope is by far the better.

It is usually taught that the easiest and most convenient position for patient and observer is to have the patient sitting in a straight back chair with the observer at the side of and facing the patient; on the right side for the right eye and on the left side for the left eye. I have for many years seated my patient in my treatment chair and have stood up beside the patient. I can in that way shift my position more easily, changing my distance more readily and shifting from one eye to the other easier and quicker for the purpose of comparison.

In no other part of the body is it possible to view blood vessels and nerve tissue directly and to watch the changes going on in these tissues incident to circulatory disorders and nerve degeneration, such as found in Bright's disease, diabetes and arteriosclerosis.

In the time at our disposal it is not possible to take up and discuss all the conditions that can be discovered and studied with the ophthalmoscope and therefore I will choose a few of the more important ones frequently encountered.

RETINITIS OF PREGNANCY

When the patient complains of disturbed vision during pregnancy, ordinarily it means a very serious condition and the ophthalmoscope may disclose hemorrhage, edema of the retina, engorged blood vessels and exudates in the vitreous, and if found early in the pregnancy may be the deciding sign as to whether early abortion is necessary. Vision of the mother at this early stage is of more consequence than the life of the child.

ALBUMINURIC RETINITIS

Usually both eyes are affected but to a different degree. Loss of vision may be complained of. Inspection of eyeground may show large white foci of exudation near optic disk or white spoke like lines about and running toward the macula like the spokes of a wheel—several discreet hemorrhages may be scattered over the fundus—the veins look distended and tortuous.

BRAIN TUMOR

Of great importance indeed is the ophthalmoscope in diagnosing this condition. A choked disk is present interfering with the blood flow through the veins causing them to be distended and tortuous. The arteries show thinning and margin of disk somewhat indistinct. The disk seems to stand right out toward you. Oft times in the early stages, other than a persistent headache, there may not be any symptoms present to indicate brain tumor, even the vision remaining undisturbed for a long time. An early diagnosis is absolutely necessary if measures are to be taken to preserve the patient's life—therefore if a few symptoms can be backed up by ophthalmoscopic findings, much good may be obtained.

SEROUS DETACHMENT OF RETINA

This condition is often found in myopic eyes. Usually comes on suddenly without pain or history of injury. One eye only is ordinarily affected. The patient explains that he can see better in one direction than he can in another. No discoloration of eye and no tenderness to pressure. The ophthalmoscope reveals a pink reflex in part of the field but the rest looks grayish-white showing many folds and a wavy movement when the eye is moved. The blood vessels stand out distinctly and follow in and out the folds of the retina. Part of the disk is usually obscured by the folds of the retina.

Ophthalmoscopic findings may be present in tabes long before any other symptoms show.—Sharply defined optic disks, bluish-white in color, outline regular and possibly slightly depressed. Lamina cribrosa markings are usually distinct. The pigment around the margin of papilla is usually undisturbed. The retinal vessels, for a long time, maintain their normal appearance, size and distribution.

THROMBUS

Sometimes a thrombus forms completely closing the central retinal vein and a typical ophthalmoscopic picture results.—The veins are much overdistended and tortuous. Many splash-like hemorrhages are present causing the fundus to have a very dark red color. The arteries are thin and often covered so that they are not easily seen.—In direct contrast to this picture is that in the case of an embolus forming in the central retinal artery, which shuts off the flow of blood to the retina. The fundus quickly takes on a dirty whitish appearance, arteries are contracted and thread-like. The fovea remains free and by contrast with the rest of the bleached fundus the red spot stands out with great distinctness. The margin of the papilla is rather indistinct.

I am going to mention just one more condition, the ophthalmoscopic picture of which is usually

typical and almost always about the same, especially after the condition has been present for any length of time. What I have in mind is glaucoma simplex. External appearance may be perfectly normal except perhaps a very slightly dilated pupil. Mediae perfectly clear allowing a clear view of the fundus. The disk shows very white or may be greenish gray—and an excavation of the entire disk. The bloodvessels break sharply over the edge and disappear only to reappear deeper in. The veins are usually somewhat distended and tortuous, the arteries somewhat diminished in size.

You understand that the details of these word pictures have necessarily been omitted and only a general summing up given.

A few colored charts on hand, for comparison, of the commoner conditions make a very profitable and interesting beginning in ophthalmoscopy.

327 E. STATE STREET.

COMPLICATIONS OF OTITIS MEDIA INVOLVING THE PETROUS PYRAMID

By W. H. EVANS, M.D., YOUNGSTOWN, OHIO

INVOLVEMENT of the labyrinth and petrous pyramid secondary to infections of the middle ear and mastoid occurs often enough in the practice of every otologist to warrant a discussion of the subject at this time.

All modern texts of otology discuss fully the symptoms, diagnosis, and treatment of labyrinthine infections. In a review of literature of the past few years much will be found pertaining to infections of the labyrinth and of the petrous pyramid. Those of Perkins (1), Wheeler (2), Sears (3), Profant (4), Eagleton (5), Kopetzky and Almour (6), and Myerson, Rubin and Gilbert (7) being worthy of special consideration.

Patients seen in practice by my associate, Dr. H. J. Beard, and myself are illustrative of some of the different types of infection of the labyrinth and petrous base.

REPORT OF CASES

Case I—E. S., male, age 51, was seen February 17th, 1931, with a bilateral acute otitis media. Myringotomy was performed and the patient sent home. Two days later the patient was brought to the office with the history of a marked dizziness which had come on twenty-four hours previous. He had a spontaneous nystagmus which was more marked when looking toward the right; absent when looking toward the left. There was a complete deafness of the left ear, and the patient was very irritable. He was admitted to Youngstown Hospital. Bromides gr. XXX q. 3 hours. *X*-ray of mastoids by Dr. Baker, negative; urine negative except for albumen 1-plus which later increased to 4-plus. Blood count negative except for a slight anemia. Spinal fluid examination negative; blood and spinal Wasserman negative. Patient perspired profusely. Nine days after he was admitted to the hospital the patient was able to hear from the left ear and the nystagmus was nearly absent, although the ears continued to discharge. He was lethargic and there was a suggestive Babinski and an increase of knee jerks. He was seen by Dr. O. J. Walker and by Dr. D. H. Smeltzer but no localizing symptoms could be found. Due to drowsiness the bromide was discontinued. Several days later the hearing and general condition began to improve and he was discharged from the hospital on March 17th, 1931, twenty-seven days after admission.

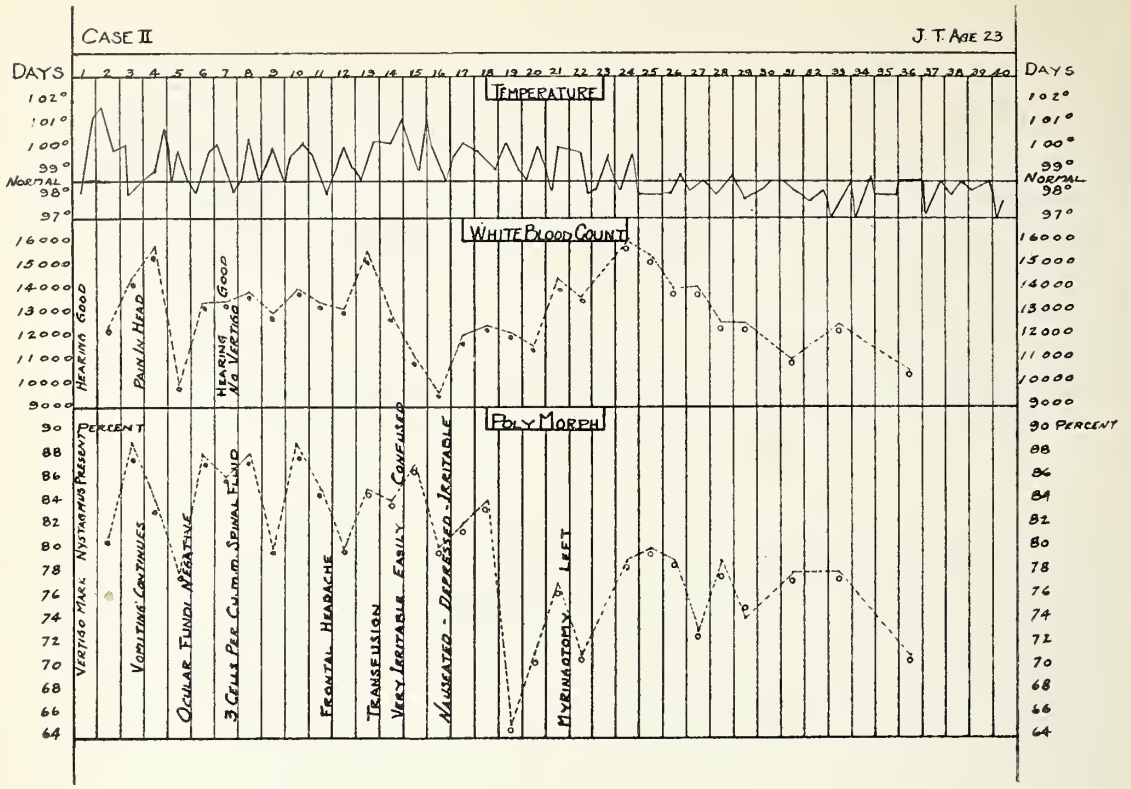
COMMENT

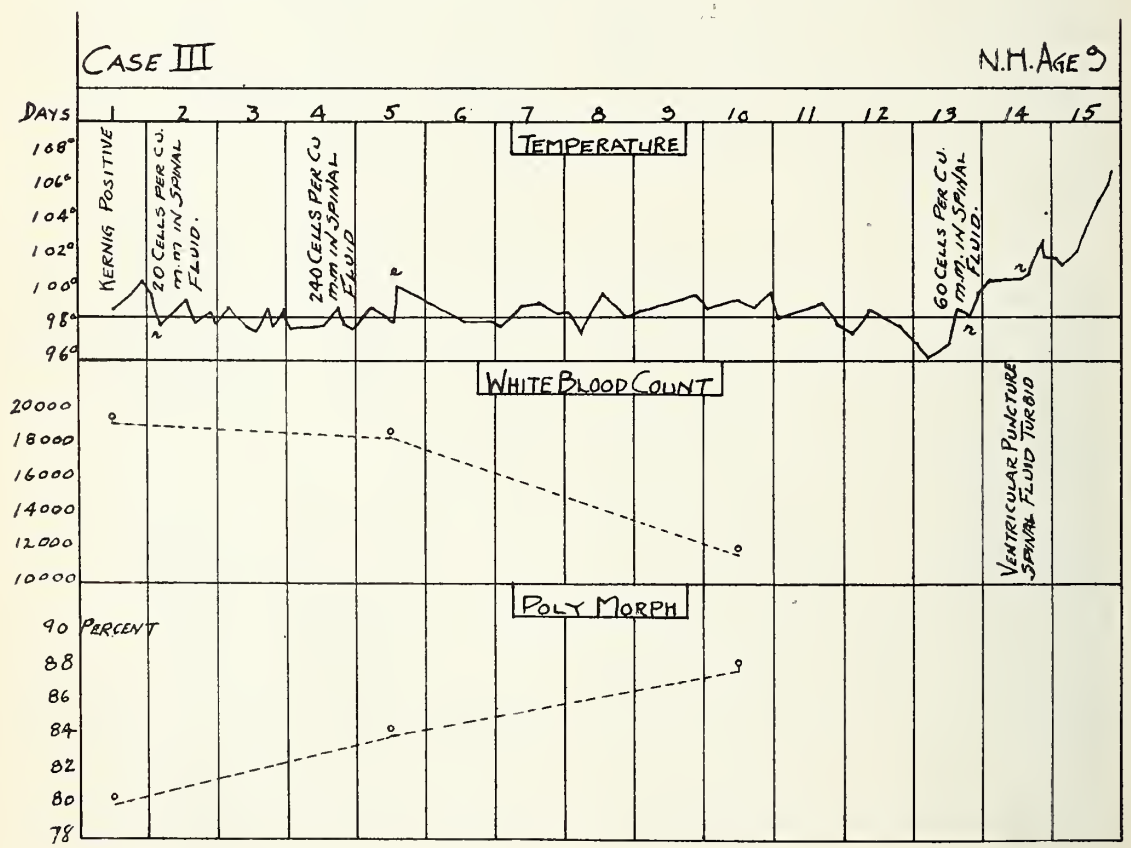
This was a case of a serous labyrinthitis and an associated nephritis with only a slight involvment of the mastoids, which was confirmed by *X*-ray examinations on three different occasions during his stay in the hospital. The blood examinations showed only a slight increase of leucocytes in the early stage of the infection. A slight secondary anemia developed, due, no doubt, to the nephritis as well as to the otitis media and labyrinth involvement.

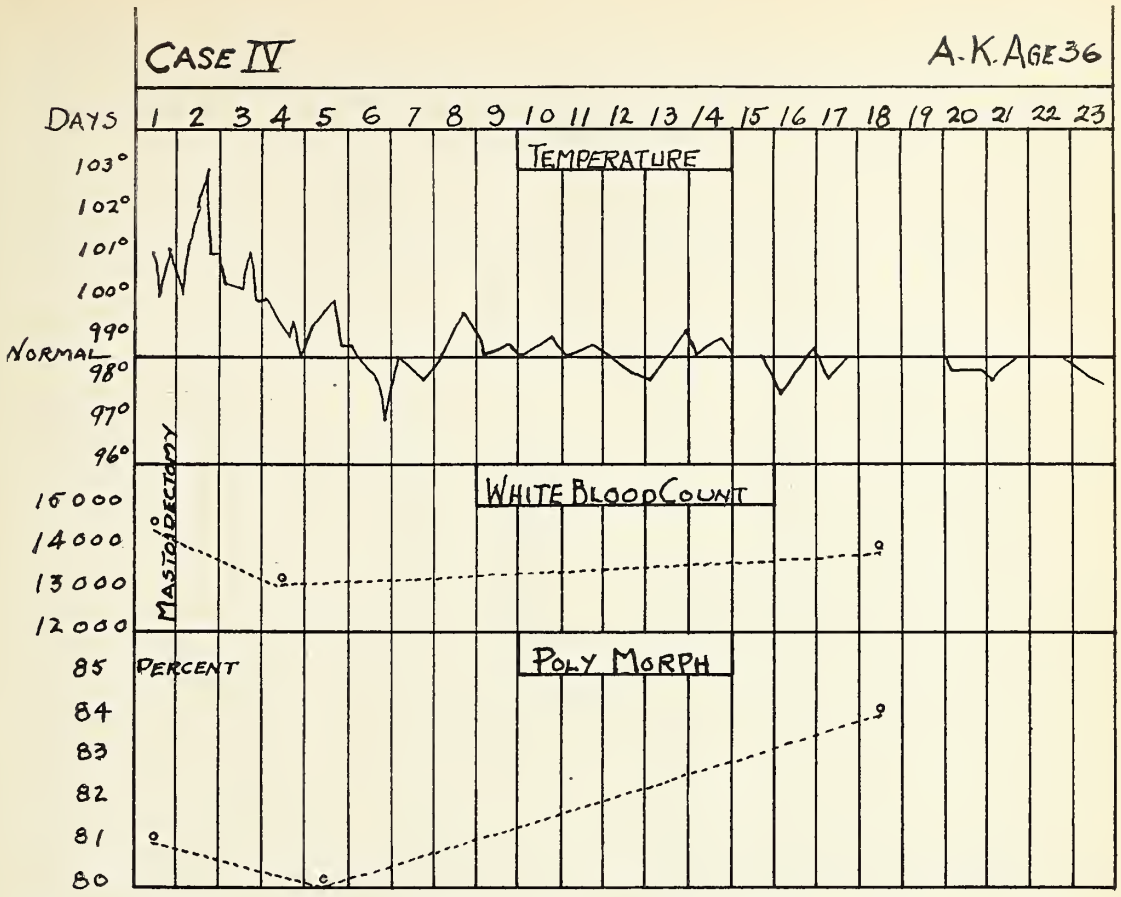
Case II—J. T., a female, age 23, was seen in our office on March 6th, 1932, suffering from an acute otitis media right. A myringotomy was done. On March 11th, five days later, she was seen at her home and gave a history of vertigo, nausea, and vomiting for the past ten hours. There was a fine nystagmus which was increased on looking toward the left. Hearing was good. Ocular fundi negative. She was admitted to St. Elizabeth's Hospital, given choral hydrate and sodium bromide per rectum, pantopon for pain, and subcutaneous injection of 2 per cent glucose in saline, as she was unable to retain anything in her stomach. *X*-ray examinations of mastoids and sinuses (by Dr. S. J. Tamarkin) showed a slight clouding of the mastoid but no evidence of breaking down. There was some increase of density over the right ethmoid area and over each antrum which indicated a diseased and thickened mucous membrane. Three days later a second *X*-ray of the right temporal bone revealed an increase in density over the petrous portion in the region of the superior semicircular canal which was found to be unchanged on March 23rd, 1932, (thirteen days after admission to the hospital).

The blood count was 12,400 with 81 per cent polynuclears and remained increased during her stay of thirty-seven days in the hospital. Due to a slight involvement of hearing, persistent increased polynuclear count, and to the depression and ir-

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CASE II
J. T. AGE 23
DAYS
TEMPERATURE
NORMAL
WHITE BLOOD COUNT
HEARING GOOD
PAIN IN HEAD
HEARING GOOD
NO VERTIGO
PERCENT
POLY MORPH
VERTIGO MARK. NYSTAGMUS PRESENT
VOMITING CONTINUES
OCULAR FUNDI NEGATIVE
3 CELLS PER CU. M.M. SPINAL FLUID
FRONTAL HEADACHE
TRANSFUSION
VERY IRRITABLE EASILY CONFUSED
NAUSEATED - DEPRESSED - IRRITABLE
HYPINATOMY LEFT


CASE III
N.H. AGE 9
DAYS
TEMPERATURE
KERNIG POSITIVE
20 CELLS PER CU. M.M. IN SPINAL FLUID.
240 CELLS PER CU. M.M. IN SPINAL FLUID.
60 CELLS PER CU. M.M. IN SPINAL FLUID.
WHITE BLOOD COUNT
VENTRICULAR PUNCTURE SPINAL FLUID TURBID
POLY MORPH
PERCENT



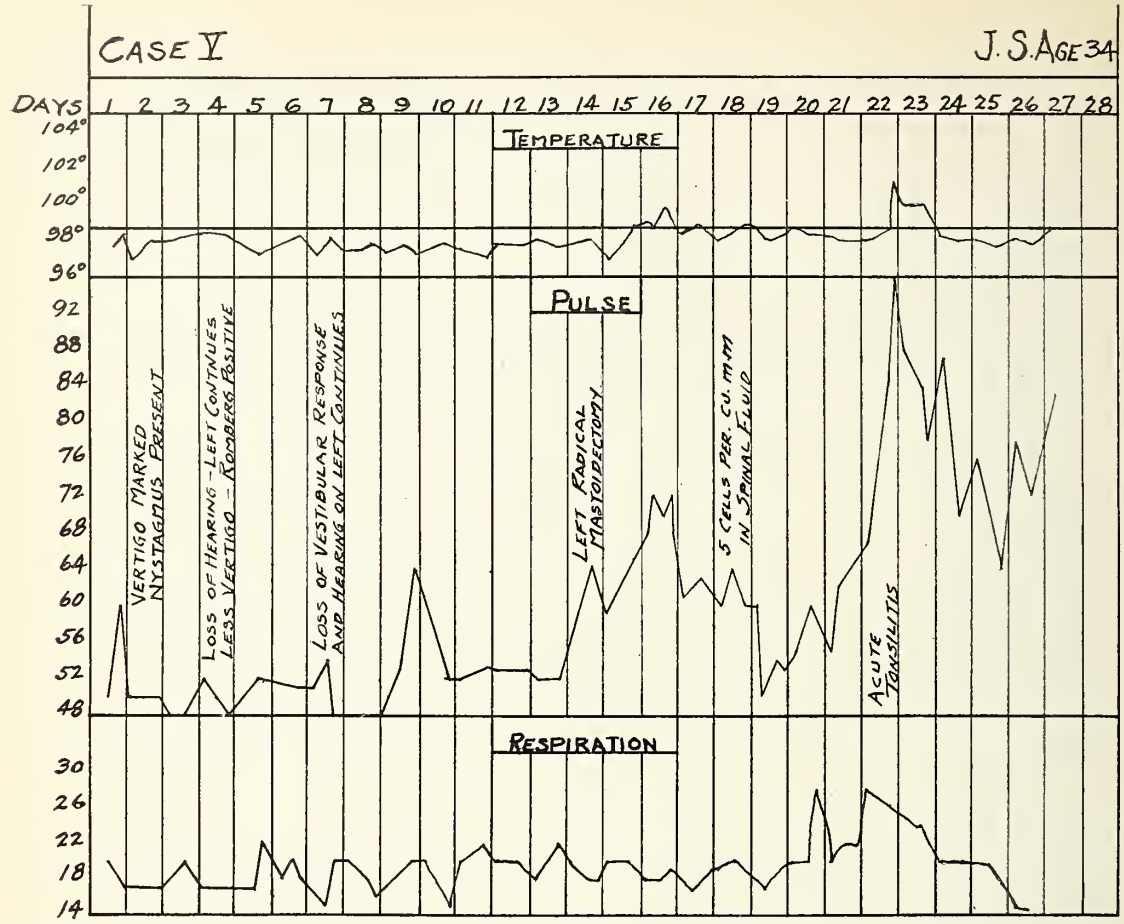
ritability of the patient, on March 18, 1932, Dr. James Gardner was asked to see her. Neurological symptoms of slight significance were found. He advised blood transfusions if no improvement was noted. Four days later she was given 500 c.c. of citrated blood by Dr. John Hardman. Following this, nystagmus continued to decrease and hearing remained good, but the patient's mental attitude and general condition were unimproved for several days. Twenty days after admission to the hospital myringotomy was done on the second ear. This was a mild infection which discharged slightly and cleared up in a few days. *X*-ray of the chest was negative. Patient was discharged from the hospital on April 20th, 1932.

COMMENT

In correlating the findings one must conclude that the patient had an irritation of the labyrinth due to the perilabyrinthine infection and that the persistent leucocytosis which was present at the time of discharge from the hospital, but which was found to be normal six weeks later, was due mainly to the infection of the petrous pyramid. While it is admitted that except for headache the symptoms were not suggestive of a petrous base envolvement and evidence of infection was arrived at by *X*-ray study, I can see no other explanation. It is worthy of note that the temperature dropped to near normal a few days after admission to the hospital and was never more than would be expected in a mild infection of the middle ear.

Case III—N. H., age 9, admitted to St. Elizabeth's Hospital on March 10th, 1928, with a history of marked vertigo and frequent vomiting spells for the past twenty-four hours. A bilateral myringotomy had been done at the home several days previous to admission. He was found to have a spontaneous lateral nystagmus which was increased on looking toward the right. The hearing was diminished no more than would be expected in any uncomplicated middle ear infection. Discharge was scanty; Kernig positive; spinal fluid clear; no increase in pressure; cell count 20 per cu. mm.; smear and culture of fluid negative. Three days after admission to the hospital there were 240 cells per cu. mm. in the spinal fluid. Smear showed polys and lymphocytes, no organism. The culture showed no growth. The neck was stiff and Kernig was positive; other symptoms were unchanged. The nystagmus continued; the patient was irritable and complained of headache. His hearing remained good for ten days after admission but the general condition was worse.

Twelve days after admission he was seen by Dr. E. W. Day who found a partial loss of coordination of the left arm and a weakness of the entire left side; spinal puncture, pressure of 80, Ayer monometer (normal 130-140); cell count 60 per cu. mm; culture negative. No response was obtained by douching either external audi-

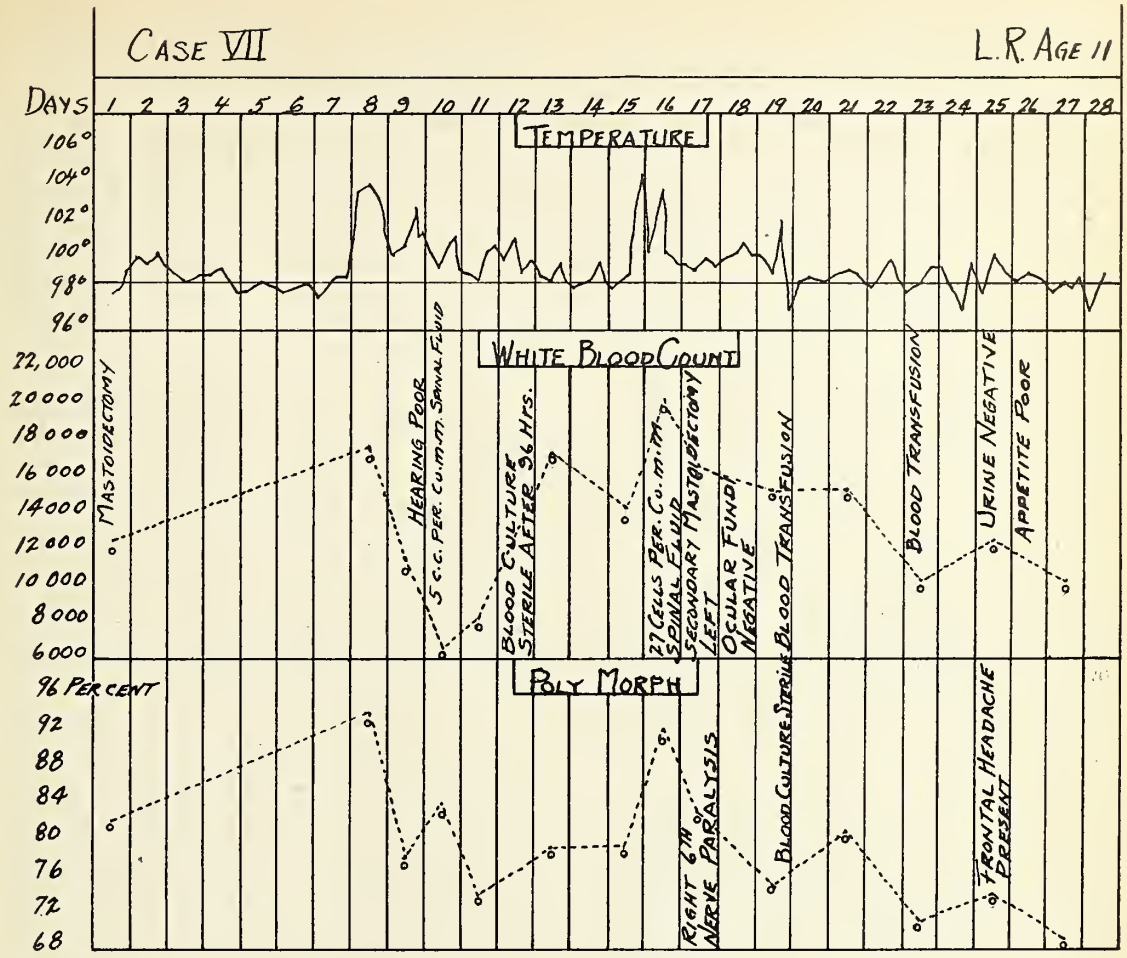


tory canal with water at 52° F. Neither ear was discharging. A second puncture made after a lapse of about one hour produced no fluid, nor did a cisterna magna puncture. From our findings it was concluded that there was an involvement of the left cerebellar region with a probable block of the fourth ventricle. The following day I assisted Dr. H. M. Osborne in a ventricular puncture from which about 30 c.c. of very turbid fluid was removed. The evening of the fourteenth day he expired and at the autopsy Dr. R. B. Poling's findings were: "The meninges were negative; the cerebrum negative. After the tentorium cerebelli was removed, the cerebellum began to ooze purulent matter on slight manipulation. The brain was removed, a culture taken, and the greater portion of the cerebellum was found to be involved in abscess formation." The temporal bones were not examined.

COMMENT

In reviewing the case I am of the opinion that the labyrinth was never involved, but that the infection was carried direct to the cerebellum by the blood stream and that the nystagmus was due to the cerebellar involvement. It is also interesting to note that the auditory apparatus remained intact as long as he was conscious, even though the vestibular function was lost. In addition, it should be noted that the continued increase of total white cells and neutrophiles was far more indicative of a virulent infection than was the temperature curve or the spinal fluid findings. The temperature was only slightly increased until a few hours before death and the spinal fluid showed very slight change compared to the marked involvement of the cerebellum. The culture of fluid remained negative throughout, but streptococci was grown on culture taken from a necrotic portion of the brain.

Case IV—A. K., male, age 36, developed a left acute otitis media on March 31, 1932. The same day a myringotomy was done. Two days later he was seen at his home and complained of a marked vertigo. He had been vomiting for the past twelve hours. He was immediately taken to the Youngstown Hospital. Examination revealed a rotary nystagmus, more marked on looking toward the right. Pupils were regular and equal and reacted normally. There was a total loss of hearing of the left ear but the right ear was negative. There was a slight weakness of the left facial nerve. A caloric test of the left ear did not change the type of nystagmus, neither did it increase the nausea or vertigo. Kernig was negative. There were 14,400 W.B.C. with 81 per cent polynuclears. Spinal fluid contained 106 cells per cu. mm., 95 per cent of which were polynuclear leucocytes. There was also a trace of globulin present. Culture of fluid negative for organisms; spinal fluid Wasserman, negative. *X*-ray of mastoids showed the left side clouded



over its entire extent, with apparent breaking down in the region of the antrum and of the tip. On the evening of the day of admission to the hospital a simple mastoidectomy was done and we found that the intercellular walls were softened throughout, especially in the tip. There was a small exposure of lateral sinus below the knee but no exposure of the dura.

Following the mastoidectomy the patient's temperature dropped from 103° F, and on the fifth day it became normal, to remain so until his discharge, twenty-four days after admission. The vertigo improved daily and had disappeared on the sixth day, but the nystagmus was present for fourteen days following the operation. It is significant to note that all blood counts, the last of which was made seventeen days after the operation, were over 13,000, and contained at least 80 per cent polynuclear cells, which was the only sign of continued infection.

COMMENT

The patient has remained deaf in the left ear but the facial paralysis has improved until there is only a slight weakness at the present time.

The findings indicate a labyrinthitis with meningeal irritation which nature was able to wall off in a short time. The facial nerve could have become involved from edema or infection anywhere from its entrance to the temporal bone at the internal auditory meatus to its exit at the stylomastoid foramen.

Case V—J. S., white, male, age 34, gave a history of a bilateral chronic otitis media since he was a small boy. On June 1st, 1928, he was forced to quit work due to vertigo. The following day he was brought home from work suffering extreme nausea and dizziness. He ate a small amount of food but was unable to retain it. Six days after the onset of symptoms, he was seen by my associate, Dr. H. J. Beard, who referred him to St. Elizabeth's Hospital. Examination revealed a purulent discharge from both ears, the left much more profuse than the right. There was a spontaneous nystagmus, rotary in type, which increased on looking toward the right. Caloric examination produced no reaction after irrigation of the left ear for five minutes with ice water. A caloric examination of the right ear produced a marked lateral nystagmus with an increase in vertigo. With Barany noise apparatus in the right ear, the patient was unable to hear from the left. Weber lateralized to the right ear. He was barely able to hear a tuning fork by air conduction with the right ear, but bone conduction was increased. During his first two weeks in the hospital his temperature remained sub-normal and his pulse rate ranged from 48 to 64 per minute, and the respiration from 18 to 20 per minute. The spinal fluid and fundi were negative and a

positive Romberg was noted, but no other neurological signs were present.

On June 21st, 1928, a left radical mastoidectomy was done. A large area of dura above the antrum in the middle fossa was found exposed, also an area of dura in the posterior fossa just medial to the lateral sinus was found exposed. Both areas were thickened and red. Two days following the operation the pulse rate and the temperature increased to near normal but the nystagmus continued. On the fourth day following the operation the pulse rate again dropped to 50 per minute and was associated with a subnormal temperature. Dr. C. S. Beck and Dr. K. M. Day saw him but no cardiac nor neurological evidence was found to account for the slow pulse. Romberg was negative at this time. A few days later the patient developed an acute tonsillitis which subsided and he was discharged from the hospital twenty-six days after admission. For some time subsequent to discharge from the hospital he complained of general weakness and headache but his pulse rate remained above normal. There was also a slight nystagmus present.

The patient has been examined on several occasions during the past three or four years and his pulse rate has been found to be slightly subnormal. It is also interesting to note that he has considerable hearing, the last audiogram showing a 38 per cent loss of hearing in the right ear, and a 60 per cent loss in the left. The left labyrinth is also active to caloric examination at this time.

COMMENT

This case was presented in the hope that discussion will bring out a more plausible explanation than edema or localized infection to account for the slow pulse and decreased temperature which returned to normal for only a few days following mastoidectomy. Just criticism might also be made for the delay in doing the mastoidectomy, even though many competent otologists advise delay in this type of case.

Case VI—P. S., male, age 6, was seen December 24th, 1925, suffering from an acute mastoiditis of the right side. He gave a history of an otitis media which came on following an attack of scarlet fever. The drum membrane had been incised and the ear had discharged for three weeks before the canal and middle ear became dry. Four days before he was first seen by us the ear began to pain. On December 26th, a right simple mastoidectomy was done and he was sent home on January 9th, 1926. While he was at home he complained of pain of the right frontal region, and did not sleep well. He was readmitted to the hospital eight days later with a paralysis of the right external rectus muscle. The wound had done poorly and the discharge was profuse. The temperature remained near normal. He continued to complain of right frontal headache and was very depressed and irritable.

On January 29th, 1926, a secondary mastoidectomy was done. The wound was found to be filled with infected granulations and there was a softening of the bone in the region of the antrum and horizontal semicircular canal. On the day following the operation, considerable improvement was noted. He was more cheerful, did not complain of frontal pain, and the external rectus paralysis was much improved. When he was sent home from the hospital on February 13th, the external rotation of the right eye was nearly normal. This continued to improve until tests with the colored glass revealed no diplopia. The mastoid healed promptly and satisfactorily.

On June 9th, 1927, fifteen months later, he was again brought to the office with the history that the right ear had begun to discharge several days previous, following an attack of measles, and that the night before the mother had noticed a swelling behind the right ear. A simple mastoidectomy was done which resulted in an uneventful convalescence and recovery except for the fact that his hands and feet began to peel which indicated that he had had scarlet fever instead of measles.

COMMENT

The points of interest are that we have Gradenigo syndrome with a subsequent middle ear and mastoid infection on the same side with no evidence of a recurrent infection of the petrous base. Also that during the time when so much is being written on the subject we should not forget that the vast majority of infections of the petrous base and tip clear up spontaneously or following a secondary mastoidectomy. This experience of a mistake in diagnosing scarlet fever reminds us that it has been found that a small percentage (about 3 per cent) of cases of scarlet fever have the second attack. Also, that it is very easy to confuse measles and scarlet fever and to diagnose one when the other is present. For that reason it would be a wise plan to quarantine all patients with a discharging ear following either condition even though measles cannot be transmitted by discharge from an ear secondary to the condition.

Case VII—L. R., male, age 11, admitted to Youngstown Hospital on April 17th, 1932, with a bilateral acute mastoiditis secondary to otitis media of several weeks duration. A double, simple mastoidectomy was done by Dr. Beard. Culture from the mastoids was streptococcus hemolyticus. The temperature was 98, and, except for a slight post-operative rise, remained normal until the eighth day, when there was a sudden rise to 104° F. He complained of pain just above the left knee. There was a slight lateral nystagmus on looking toward the right. The following day it was noted that his hearing was much impaired. The throat, chest, and abdomen were negative. On admission to the hospital there were 12,500 W. B. C. with 81 per cent neutrophiles. On the day the first signs of complications arose, the W. B. C. were 17,850 with 94 per cent neutrophiles. Tobey-Ayer test on the tenth post-operative day was also suggestive of an involvement of the left lateral sinus. The pressure was 120 cu. mm. of water. With pressure over the left jugular the fluid rose to 150. With pressure over the right jugular the fluid level rose to 220. Pressure on both jugulars brought the fluid to 360. Six c.c. of fluid was removed and found to contain a trace of globulin with 5 cells per cu. mm.

Two days later a second Tobey-Ayer test gave the same result, but there was an increase of cells in spinal fluid to 27 per cu. mm. Blood culture was reported negative; urine negative. After the intial rise to 104° F, the temperature gradually

subsided, ranging from 99° to 100°, but the nystagmus and impaired hearing were unimproved. On the sixteenth day there was a second rise of temperature to 104.6° F, and it was decided to expose the left lateral sinus. This was done but the vessel appeared normal. On the same day a right sixth nerve paralysis was noted. On the nineteenth day after admission, he was given a transfusion of 400 c.c. of citrated blood as there had been a decrease of over one million red blood cells to 2,660,000, and a decrease of 18 per cent hemoglobin to 47 per cent. A second transfusion of 300 c.c. was given on the twenty-third day.

Following the first tranfusion the temperature dropped and remained between 99° F and 100° F, but the patient continued to be very irritable, and complained of severe frontal headache. Hearing continued diminished in both ears. The right sixth nerve paralysis and nystagmus were still present, and remained so as long as he was in the hospital. Fundi were negative as were the culture of blood and spinal fluid. At different times during his stay at the Youngstown Hospital he was seen in consultation by Dr. J. M. Waugh, Dr. James Gardner, and Dr. S. M. Hartzell. On May 14th, 1932, twenty-eight days after admission to the hospital, he was transferred to the service of Dr. Wells P. Eagleton at the Newark Eye and Ear Infirmary where he remained for 11 days. Six days following his arrival in Newark, we received the following report from Dr. Eagleton:

"I expected to send your case back to you and told the father to go back but would like to keep the boy yet for a few days longer. He is very much better. He has had no more vomiting and no more pain in his head. He was never dizzy. However, when we turn him he has a complete loss of reaction to the turning test and also to the caloric test although the boy hears. If it were not for this I would return the boy feeling sure nothing would happen but experience teaches that when a loss of the vestibular reactions occurs in suppurative lesions some cases have infection around the internal audiotory meatus.

"He had pain over the first branch of the fifth and an external rectus paralysis which I think he has always had. The most important thing of all is the loss of the vestibular reactions."

The *X*-ray report is as follows:

"Sinuses—normal condition, no variation in density.

Mastoids—shows lessend density right petrous apex from the semi-circular canal to extreme apex. Lateral view, some osteomyelitis adjacent to the apex area. Anterior posterior view left side lessened density showing some mottling which may be due to sequestrum."

A series of five visual field made at Newark were negative.

COMMENT

The boy made a slow but uneventful recovery. The external rectus paralysis has cleared up entirely, but his hearing remains impaired. A recent audiogram showed a 47 per cent loss in the right ear and a 61 per cent loss in the left ear.

It is interesting that simultaneously there existed evidence of an involvement of the left lateral sinus, the right petrous apex, and a labyrinthine involvment with recovery by resolution.

CONCLUSIONS

Here are seven cases illustrating different clinical types of involvement of the labyrinth and petrous base. Two of these showed evidence of involvement of both areas simultaneously.

One case is reported of involvement of the petrous tip with recovery, and a subsequent mastoid infection of the same side with no involvement of the petrous tip.

Analysis of the cases show that there is often a continued increased white count after other symptoms indicative of involvement of the labyrinth have subsided.

24 WICK AVENUE.

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DISCUSSION

RUSSELL G. MEANS, M.D., Columbus: Dr. Evans is to be congratulated for reporting this series of very infrequent cases. It is not often the good fortune for so many of this unusual type to fall into our hands unless one is associated with a very large clinic which receives these patients late in the disease. I think very good judgment was used in the cases where transfusions were given. In my experience in cases of overwhelming infection or with those having serious complications I find blood transfusions of very great value. In fact, serums have been almost useless in my hands, but repeated small transfusions have been the means of bolstering up the resistance and saving the lives of many of these cases.

I have had several cases of chronic mastoiditis in recent months that the involvement was very deep around the labyrinth and approaching the petrous area. However, none had the complications that Dr. Evans illustrated in his paper.

Referring to the bradycardia case; frequently there are other hidden foci in the body, or a toxemia such as follows influenza, that alters the general picture. I find more of the serious complications arise in those cases that are taken suddenly ill with a high temperature and show an overwhelming reaction. Even though resolution occurs up to a certain point there is definite evidence of some mastoid involvement and a continued discharge from the ear, which, of course, keeps us on the alert. I remember a case that was taken suddenly ill following influenza and was at the point of prostration when the middle ear involvement began and rapidly presented a complicating mastoiditis. Following operation there was an erysipeloid swelling and the patient was unable to leave the hospital for six weeks. Tachycardia and general weakness persisted for

many months and led to semi-invalidism. The heart sounds were normal; however, years later by electro-cardiogram she was found to have a block of the right branch of the bundle of Hiss.

The time to do a mastoidectomy is an individual problem with each case. It depends on impending complications and the severity of the symptoms. No general rules can be followed. The careful treatment and complete diagnostic procedures as were carried out in the above series of cases leads to commendation and an example for others to follow.

— OSMJ —

Blood Pressure

An Effective Method of Control

By W. F. BROKAW, M.D.,
CLEVELAND, OHIO

HOW is your blood pressure—is a question almost as common as the salutation "How are you?" and the man who finds that his pressure is around the 200 mark is made to feel that he has entered a stage where there is cause for apprehension, careful medical advice, restriction of diet and physical activities. His whole outlook upon the future is one of apprehension and uncertainty—for until very recently none of us could offer any definite method of control or cure.

Just why the adrenal glands and the pituitary supply an excess, or the reverse, of the pressor secretion—or on the other hand just the right amount to keep the pressure of the average individual at what we consider normal and safe, no one has ever satisfactorily explained. The more recent idea that the nerve supply to the adrenals affords the answer, seems, in the light of observations during the past three years, more nearly to the point—and apparently some surgeons acting upon that assumption have attempted to sever some of that nerve supply—leaving the trusting individual to a dubious future.

On October 22, 1931, a wholly unexpected result from a simple treatment for other conditions afforded material for very sober thought and observation. To have a pressure of 230 drop to 200 with a five-minute treatment—where it still remained when tested again the next day, when another such treatment was given which dropped it to 185, and the patient feeling unusually well, made it imperative that we attempt to find out why this should occur in this way. To that end, one after another with hypertension were subjected to the treatment, with similar results—results often incredibly spectacular—as, a woman who came in recently with a splitting headache which she had had for two days. Her pressure was 270, but after a five-minute treatment it dropped to 210, and she said she felt perfectly normal, and free from any trace of headache. Another such treatment a week later dropped it to 170.

With the average individual the drop will be anywhere from 15 to 40 points, and there has never been observed the least trace of dyspnea, or seeming let-down. On the contrary, there is a better feeling than before the treatment. Occasionally by making the treatment more intense the pressure may run up anywhere from 15 to 30 or more points, but when tested ten to fifteen minutes later it usually will be found to have dropped much below the initial point. That such treatment can do much to change the old hardened arteries of the man around 80 should not be expected, although with one such individual some months ago with a pressure around 225, which had existed for a long time, a treatment every three or four days for a time would occasionally drop it to 170, and he admitted that it kept him feeling better than usual.

The average hypertension case with treatments at intervals of from one to several weeks is kept most of the time with a pressure of 20 to 40 points lower than before, feeling physically improved, and relieved of the constant apprehension of possible disaster so that it is only reasonable to presume that such treatments should keep most of these cases at a safe level most of the time, and that without having to resort to the rigidly restricted diets, the nitrites, and many other things we have thought so necessary.

This simple treatment is given by using the current from a sine wave electric machine, applying one wet electrode to each leg just below the knee, and using a current just strong enough to make fairly sharp contraction of the muscles. On the Morse machine the current indicator is set at about 3½ to 4—and using a cam which makes 11 surges to the minute—which runs the current from zero up to the highest point indicated, and then drops back to zero again. As stated above, the treatments need not exceed five minutes.

There seems to be no question that the application of one electrode on each leg with the shunting of the current around through the lower part of the body has a profound effect on the sympathetic plexus—overcoming the imbalance for the time being—which in turn must have an inhibiting effect upon the adrenal secretion, for the radical effect of such applications can only be attributed to the nerve response. Certainly there can be no fulminating action from the adrenals to cause such sudden change. They may be likened to storage batteries which may or may not be kept highly charged from that highly sensitive dynamo —the sympathetic plexus, which in turn is actuated from that master switch—the brain. Intense passion or excitement of any kind too frequently repeated must induce a condition of hypertension, which ultimately becomes a habit, with all of its attendant dangerous features.

Anyone who will follow the directions indicated must be forcibly impressed with the revolutionary means at our disposal, and the simplicity of the treatment leaves no room for excuse in allowing these cases to drag along as we have been compelled to do in the past.

Records of a goodly number of cases during this period of three years are available—but anyone who may have access to a sine wave machine will quickly be convinced—and be in a position to enlist the everlasting gratitude of those who come under his care.

Much comment might be made upon the subject, but this should be sufficient to get men busy.

2301 CHATFIELD DRIVE.

PUBLIC HEALTH -- SOCIAL WELFARE -- MEDICAL ECONOMICS *and* ORGANIZATION PROBLEMS

First Call For 1935 Annual Meeting At Cincinnati

Although the 89th Annual Meeting of the Ohio State Medical Association is several months away, it is not too early for members to make plans for attendance at the sessions, which will take place at the Netherland-Plaza Hotel, Cincinnati, Wednesday, Thursday and Friday, October 2, 3 and 4. The various committees are working diligently to make this one of the most interesting and entertaining meetings in the history of the association.

Members of the Association well know the unusual opportunity that attendance at this meeting affords them to keep abreast of scientific developments. Increasing public interest in health and medical questions emphasizes the reasons why all physicians should take advantage of the occasion that the Annual Meeting presents to familiarize themselves with scientific advances as well as economic, social and governmental problems, confronting the medical profession.

The Scientific Exhibit, meeting of the House of Delegates, discussions in the various scientific sections, organization luncheon, the medical and surgical clinics, and the annual dinner all provide a source of information that members of the Association just cannot afford to miss.

It is hoped that a large number of members will make plans now to attend the Annual Meeting. The first step is to make reservation for hotel accommodations, full information concerning which is printed elsewhere in this issue of *The Journal*. Send in your reservation today.

—OSMJ—

Legislature Quits; Continued Activity by Physicians Imperative

As this issue of *The Journal* went to press, the 91st Ohio General Assembly was winding up its regular session.

In many respects this session of the State Legislature was one of the most hectic in the state's history.

This was partially due to the fact that an unusual number of important questions was before the Assembly for consideration and on the other hand due to the strong sentiment which prevailed among certain blocs within the Legislature for extensive experimentation and radical changes not only in governmental set-ups but in statutes affecting the social and economic life of the people generally.

It will be gratifying to the medical profession of the state to know that nothing detrimental to the public health and medical standards of the state has been enacted.

This does not mean that no efforts were made by cultists, anti-medical groups and radicals to materially weaken, if not destroy, the safeguards that have been established for the preservation and improvement of the health of the public and the standards which insure the highest caliber of medical practice.

Quite the contrary was the case.

The Committee on Public Policy was forced to work at top speed throughout the five-months session to prevent the enactment of destructive proposals. Because it worked hard and effectively and because it received splendid cooperation and assistance from many of the component county societies and academies, the committee was able to counteract and defeat groups seeking changes in the statutes that would have had a detrimental effect on the public health and welfare.

The majority of the membership of the 91st General Assembly deserves commendation for refusing to enact proposed legislation that was unsound from a public health and medical standpoint. *It is hoped that every physician will make it a point to express his appreciation to the members of the Legislature from his county and district whose records show that they were correct on issues in which the profession was vitally interested.*

Those sponsoring proposals to which the medical profession was opposed were successful in securing considerable political pressure for their measures. More politics was played and more vote trading attempted on health and medical issues during this session of the Legislature than ever before.

This situation, which at times reached a point where the proven friends of public health and high medical standards among the members of the Legislature were subjected to strong pressure in an effort to win their support for anti-medical bills, indicates that renewed interest and activity in political and legislative affairs on the part of the medical profession are imperative.

There is no need for physicians to be partisan in such activities. It is essential however that

they use their influence in seeing that only those with correct viewpoints on health and medical questions are elected to public office, regardless of their party affiliations.

If time and space permitted, an illuminating review could be written concerning the experiences of the Committee on Public Policy during this session of the Legislature.

A recapitulation of some of the observations of the committee during the legislative session reveals the following:

1. Physicians generally still ignore the importance of an active interest on the part of the medical profession in local public affairs, including political activities. Criticism regarding the apathy of their physician constituents was voiced frequently by members of the General Assembly. Some legislators frankly admitted that they have never been seen or interviewed by representatives of their county medical society. Others were poorly informed on medical and public health questions until interviewed by members of the Policy Committee. Few received communications from the physicians of their county or district, but many were swamped with letters from the proponents of proposals to which the medical profession was opposed. As long as this situation exists, the enactment of legislation inimical to public health and medical standards is a constant menace. Potentially the medical profession is a group of great strength and influence in public affairs. Experiences of the past few years have demonstrated the weakness of the profession in its public relations and the need for prompt adjustment. The increasing interest of the public in medical questions and the growing danger of political domination over medical and health activities emphasize the necessity for active participation by all physicians in civic and political affairs.

2. Some legislative committeemen are shirking their responsibilities. Elected to direct local legislative activities, act as a coordinating agency with the Policy Committee, and as a source of information for members of their respective county societies, some committeemen devote little, if any, time or effort to these important matters. Frankly, committeemen not sufficiently interested to do their job well, should resign. County societies should give more thought to the selection of their legislative committeemen.

3. Some county societies have neglected to reserve a place on their programs for a brief, but comprehensive, discussion of social, economic and legislative questions. Such discussions need not interfere with but rather be in addition to the scientific presentations. Bulletins and communications from the Policy Committee (issued weekly during the legislative session) should be read to the membership *by the legislative committeeman* and plans laid for local contacts and interviews with members of the Legislature.

Unless all signs fail, the present Legislature will be called into special session frequently during the next 18 months. It undoubtedly will be asked to consider at these, questions of vital importance to the medical profession of Ohio, for example, social legislation (which may include sickness insurance), workmen's compensation proposals, taxation, etc.

Now is the time for every county medical society and academy of medicine to strengthen its legislative machinery. Organized medicine must be better prepared to meet pending issues, many of which are of greater importance than those which have been disposed of temporarily.

Comments relative to the recent legislative session would not be complete without an expression of appreciation and praise for the outstanding services rendered not only to the medical profession, but the public generally, by the three physician-members of the 91st General Assembly, namely: Dr. F. M. Elliott, Ada; Dr. H. T. Phillips, Athens, and Dr. R. P. McClain, Cincinnati. As members of the Health Committee in the House, they actively and consistently supported the policies of organized medicine on health and medical questions and made their influence felt with the Legislature generally. The profession of Ohio owes them a vote of gratitude and commendation.

—OSMJ—

Business Warned of Dangers In Socialized Medicine

It has not been long since the display of any particular interest on the part of business and industrial groups in the question of socialized medicine was conspicious by its absence.

Times have changed. Now we find some of the strongest arguments against compulsory sickness insurance, regimentation of the medical profession, and similar ideas being raised by business leaders and industrial groups.

They have begun to realize that the complete socialization of medicine will be but an opening wedge to the complete socialization of business and industry, and that business will assuredly be called upon to foot a large portion of the bills for any and all experimental schemes of this character.

As an indication of the present attitude of business organizations, we quote from the editorial columns of *Nation's Business*, mouth-piece of the United States Chamber of Commerce:

"An assertion by a high government official that 'we are a backward country, 25 years behind Germany in health insurance,' gave us a bad morning. But, by a coincidence, the noon mail brought

a committee report of the Washington Board of Trade which dealt with, among other things, this same Germany's experience.

"'Contrary to general belief,' the conclusion ran, 'health insurance has not lowered the mortality rate in countries which have adopted it; it has not lowered the sickness rate' . . . that paradoxically the days of sickness *per capita* have more than doubled in every country with compulsory health insurance (in Germany and England rising from seven to 15 per year); that health insurance 'has not decreased the total costs of medical care' but in reality has increased it; owing to the large administrative staff (32,400 in Germany) and the high degree of political control inevitable in compulsory health insurance.

"Deterioration of the quality of medical service and retardation of professional progress are two other handicaps inherent in public insurance plans. The committee suggests that the patient's free choice of a physician and the personal relationship are nullified through the impersonality of government administration. There is no gainsaying the importance of the issues raised by the various proposals to assure the physical well-being of the citizen. Europe has provided the realistic precedent, and the development of her procedure and experience is available alike to advocate and opponent of similar provisions in this country.

"The committee is convinced that 'the change of social problems should be undertaken step by step, since every change effected inevitably changes many other aspects of the problem, and often in a quite unpredictable way.'"

—OSMJ—

Medical School Graduates and Medical Economics

A chair in medical economics has been established at Harvard University Medical School.

The medical profession will hail this as a decided step in the right direction and one that should be followed by all medical schools.

Naturally, benefits accruing from such a plan will depend greatly on the individual selected to conduct the courses and lectures and on the scope of the topics scheduled for discussion.

However, as one commentator has pointed out, instruction in medical economics if properly regulated will offer an opportunity for clear thinking based upon fundamental facts and sound evaluation of the evidence at hand.

An interesting bulletin in line with this idea has been released by the Committee on Legislative Activities of the American Medical Association.

It emphasizes the importance of informing medical graduates on the ramifications of sickness insurance and similar proposals and urges arrangements for presentation of the facts pertaining to sickness insurance, etc., before the student bodies of medical schools.

The suggestion has much merit and is one that should be given serious consideration by the organized medical society where medical schools are located.

The following excerpts from the bulletin summarize some of the points that might be covered in such presentations:

"It is reported that in some universities students soon to graduate in medicine have not been addressed on sickness insurance or given the medical practitioners' viewpoint of this problem. The House of Delegates of the American Medical Association, in 1933, adopted a Resolution pointing out the advisability of offering some training in the economics of medical practice in medical colleges. In some instances such courses have been given without discussion of sickness insurance and the experience in European countries, or plans proposed in this country. Students not having contacts among physicians in general practice have frequently received their only impression of sickness insurance from younger members of the teaching staff, like themselves without outside experience, or nonmedical sociologists and social workers. Lack of medical knowledge, and therefore lack of ability to properly evaluate the factors that enter into the care of the sick, has been evident in statements made by some of the most active proponents of sickness insurance plans.

"It has been frequently stated that senior students and recent graduates are inclined to look toward sickness insurance as a desirable means of getting a start in practice. Although complete age records of physicians employed under sickness insurance in foreign countries are not immediately available, it is not evident that sickness insurance, if instituted, would offer any advantage to the young man over his older medical competitor. The established physician, though possibly not so well trained in newer medical methods, would have the advantage of experience, patient contact and political alliance, if such legislation would reduce the major portion of the profession to the same low level of earnings. As to the future possibilities of advancement open to the practitioner in medicine, obviously the young man would have more to lose than the older member of the profession, should destructive methods prevail.

"Contact with student groups and recent graduates, and a frank presentation of sickness insurance plans and their effects, based upon a fair appraisal of foreign experience, has in each instance developed an understanding body, who are awake to this threat against their future, among

these younger medical men. Given a friendly interest and guidance, these groups will become the most effective force against the establishment of objectionable methods of practice. In some instances, faculty members have frankly admitted that, having had no experience in outside practice, they do not feel themselves competent to present the subject. It is therefore suggested that Officers of each State Medical Society contact the medical colleges of their state, and, through their faculties and student organizations, arrange for the presentation of the sickness insurance problem by someone sufficiently well informed on that subject. Each student should be given helpful literature. The American Medical Association will, on request, furnish needed supplies. Medical organizations have a definite responsibility toward these men who are about to enter the active field of medical practice.

"In addressing graduating students, the advantages of membership, as soon as possible, in County and State Societies and the American Medical Association, should be pointed out."

—OSMJ—

The Art and Application of Medical Service

Every physician knows that medicine is not an exact science. He also realizes that the practice of medicine is not merely the application of a set of scientific laws but that what is commonly spoken of as the art of medicine is an attribute that every physician must possess to assure himself of some sort of success and of being of more than average service to his patients.

Dr. Walter C. Alvarez, Rochester, Minnesota, in a discussion which has been quoted in a number of publications, describes the art of the practice of medicine as:

"The knack of dealing with the patient in such a way as to gain his confidence, his respect, and his liking; it is the knack of inspiring him with the feeling that here at last is a man who understands his case and will cure him; it is the knack of keeping this trust even when things go wrong, when health and comfort do not return, and when, perhaps, as is the case with many illnesses, things continue to go from bad to worse; and it is the knack of making the patient comfortable and of adjusting the prescribed treatment to his particular idiosyncrasies of mind and body."

The medical profession is sometimes accused by persons within and outside of the profession of devoting too little attention to the practice of the art of medicine and for placing too much emphasis on the application of rules and principles laid down by the ever-progressing science of medicine.

If this is true—many, no doubt, would challenge the accusation—it is perhaps one of the outgrowths of the modern tendency to standardize, generalize and mechanize all lines of endeavor. Probably one reason why the practice of the art of medicine has been somewhat neglected—if it has—is because the close personal relationship which has existed for centuries between physician and patient has been disturbed through the establishment of some of the so-called modern methods of medical service.

It is quite apparent that the practice of the art of medicine must of necessity be minimized in some of the new-fangled systems of medical service which operate on a mass-production and highly mechanized theory, and where speed is an essential factor; where large numbers of patients are handled in a limited amount of time, and where there is little or no intimate or friendly relationship between doctor and patient.

There is no doubt but what the art of medicine is a vital and essential factor in the production of efficient medical service, and as Dr. Morris Fishbein has stated, "any physician of considerable experience recognizes that the art of the practice of medicine, humanity being what it is, is about as important at the present time, as the science".

If efficiency of medical service depends to such a large extent on the art of medicine, therefore, the medical profession must practice on a base which will permit generous and judicious application of this art.

What system could in any sense of the word come closer to producing the ideal setting for the practice of both the science and art of medicine with a high degree of efficiency than that which has given us the family physician of historical lore and the specialist whose bread and butter depends on the type of service he renders; and which teaches the medical practitioner that his patients are human beings, not merely an element to be analyzed in the laboratory or critically examined as a part of the routine grind of a modern medical factory?

The art of medicine will continue as a dominating factor of medical service and will progress just so long as individual, competitive medical practice remains as the chief agency for the cure of human ills and suffering.

Advancement of the art of medicine, through the individual medical practitioner, is about all that will keep—to quote the editor of *The Modern Hospital*—the hospital from becoming a "soulless mill for the administration of medical treatment" and the physician anything more than an "efficient automaton".

The time is ripe for a showdown on a lot of tomfoolery masquerading under false labels, official and non-official, the fields of medicine and health being no exception.

IMPORTANT CHANGES IN MEDICAL RELIEF PLAN, FORMULATED BY POLICY COMMITTEE OF STATE ASSOCIATION, ARE SUBMITTED TO RELIEF ADMINISTRATOR STILLMAN

CHANGES in the rules and regulations governing the operation of the FERA program to provide medical care for the recipients of unemployment relief in Ohio have been recommended by the Committee on Public Policy of the Ohio State Medical Association, upon authorization of The Council, to Mr. C. C. Stillman, FERA administrator for Ohio.

The recommendations of the committee if concurred in by the State Relief Administration and put into effect will, it is believed, bring about improvements in the present medical relief set-up, alleviate many of the unsatisfactory conditions in connection with the rendition of medical service to those on relief, provide more prompt and more adequate compensation for physicians and others rendering professional service, and develop a better mutual understanding and closer cooperation between the medical profession and relief officials.

Negotiations which were climaxed by the submission on May 15 of the committee's report and recommendations to Mr. Stillman were started after serious conditions developed which made modification of the medical relief program advisable and necessary.

NEGOTIATIONS STARTED IN FEBRUARY

Last February after Mr. W. A. Walls was appointed executive director of the then Ohio Relief Commission, representatives of the Ohio State Medical Association held several conferences with Mr. Walls for the purpose of discussing with him changes in the medical relief set-up which would eliminate the necessity for the drastic pro-rating of physicians' bills, alleviate difficulties that had developed in many communities in administration of the medical program, give the medical profession greater responsibilities in assisting and cooperating with local relief directors in administrative procedures, tend to prevent abuses on the part of some participating in the medical program, and provide those on relief with more adequate medical service.

Before Mr. Walls or the Ohio Relief Commission could act on the recommendations presented to them, the relief activities in Ohio were federalized and Mr. Stillman appointed as administrator and representative of the Federal Government in administering relief work in this state.

NEED FOR ADJUSTMENTS AGREED UPON

On April 13, the Policy Committee held a conference with Mr. Stillman at which all angles of the medical relief program were discussed and the views of the medical profession forcefully presented.

At that time, Mr. Stillman stated that it was his desire and intention to try to work out improvements in the program in cooperation with the Ohio State Medical Association and, if possible, make adjustments in the procedure and financial set-up which would assure the payment of physicians in accordance with the state-wide medical fee schedule.

Mr. Stillman admitted that the medical profession had just grounds for complaint of the delay in receiving payment for medical services and of the inefficiency that existed in some of the local relief offices. He stated that the pro-rating of medical bills which was found necessary in some communities was undesirable and that an effort would be made to bring about a more equitable distribution of the funds available for medical care.

The cooperation and assistance of the Policy Committee was requested by Mr. Stillman. It was decided that the committee should make an investigation of the operation of the medical relief plan throughout the state and submit to Mr. Stillman a revised set of rules and regulations for his consideration.

RECOMMENDATIONS SUBMITTED MAY 15

Determined to present constructive recommendations designed to improve the medical relief program, the Policy Committee sought information, comments and suggestions from the officers of all the county medical societies and academies of medicine of the state and the secretaries of the state medical associations of a dozen other states relative to the medical program in their states.

Based on extensive data and numerous suggestions assembled in this way, the Policy Committee formulated a revised set of rules and regulations governing the Ohio medical relief plan and, with the approval of The Council, presented it to Mr. Stillman on May 15.

At the time this was written, the recommendations of the committee were *under consideration* by Mr. Stillman and his state headquarters staff.

In the report submitted to Mr. Stillman were incorporated the following *suggested* modifications and additions to the rules and regulations which have governed the medical relief plan since its inception in the Fall of 1933:

1. Definite provision shall be made whereby those receiving cash relief and work relief, as well as direct relief, may be provided with medical relief if in the opinion of relief officials the costs of necessary medical service cannot be met from cash relief or wages from work relief.

PROCEDURE FOR CARE OF CHRONICS

2. Medical care for prolonged illnesses, such as chronic asthma, chronic heart disease, chronic rheumatism, diabetes, and similar ailments may be authorized at the discretion of the local relief administration and upon the approval of the medical division of the State Relief Administration, on an individual basis, if there are no local facilities for the care of this class of relief patients. It was suggested that where possible visits should be limited to a specific number per week or month for a definite period, depending on the nature of the illness and the condition of the individual patient.

3. In case of emergency or when medical service is required on Sundays, holidays or after the local relief office has closed for the day, families shall be permitted to call a physician without a medical order blank. However, in such instances, notification of a visit must be given to the local relief administration within 48 hours after such services have been rendered and in each case an order must be secured before the second visit.

ORDER FORM RULING SIMPLIFIED

4. The number of visits by a physician authorized on any medical order blank and encumbrance form shall not exceed three and itemized bills must be submitted after six or fewer visits. If the case needs further care at the end of the number of visits authorized, the physician shall request an extension of time, filing with the local relief administration a written statement setting forth the condition of the patient and the reasons for such request.

5. When authorization for medical care is made by the local relief office, the order writing department shall issue a relief order, specifying the number of calls to be made and send this form to the physician. At the time of rendering the service, the physician shall secure the client's signature on the relief order and return it to the relief office with Forms RM or RO. If the relief order has not been received by the physician at the time the service is rendered, the client's signature may be secured on Form RM or RO, which subsequently shall be filed with the local relief office as evidence that the service authorized has been rendered. It was suggested that a supply of Forms RM and RO be made available to each physician to facilitate the securing the the client's signature in cases where there is delay on the part of the relief office in forwarding the relief supply order to the physician.

ADVISORY COMMITTEES SUGGESTED

6. The establishment of a state medical advisory committee and local medical advisory committees was recommended and the following insertion in the rules and regulations suggested:

"The State Relief Administration shall create a State Medical Advisory Committee, composed of the director of the medical division of the State Relief Administration, two representatives of the medical profession, and one representative of the dental profession, one of the nursing profession, and one representing the pharmaceutical profession.

"Such representatives shall be selected by the State Relief Administration from lists of qualified persons presented to the administration by the president or other proper officials of the official state organization of each profession.

"The function of the State Medical Advisory Committee will be to advise the State Relief Administration on medical questions and assist in the administration of the medical relief program.

"Each County Relief Director shall appoint a medical advisory committee to act in an advisory capacity and assist him in administering the medical relief program in his county.

"The committee shall be composed of two physicians, one dentist, one nurse and one pharmacist to be selected by the relief director from lists of qualified persons recommended by the president or other proper officials of the local medical, dental, nursing and pharmaceutical organizations, respectively.

"The advisory committee shall cooperate with and advise the County Relief Director on medical problems requiring professional judgment; assist in maintaining proper professional standards; enlist the cooperation of the constituent professional memberships in the medical relief program; and aid in the dissemination of pertinent information to those rendering professional service.

"The advisory committee shall assist the County Relief Director, his medical supervisor and/or authorization officer in supervising the medical relief program and in validating monthly bills for professional services, medicine, and medical supplies.

"Such advisory committee shall cooperate at all times with the County Relief Director in keeping the local medical relief program functioning so as to provide adequate medical care for all on the relief rolls; in checking expenditures for necessary professional service, medicine and medical supplies; in seeing that those rendering such services and furnishing such supplies are promptly and adequately compensated; and in recommending disciplinary action against those guilty of questionable practices in connection with the rendition of professional service or sale of medicine and medical supplies."

SUPERVISOR FOR MEDICAL PROGRAM

7. It was suggested that each local relief administration establish a supervisor of the medical relief program. The following insertion in the rules and regulations was recommended:

"Each County Relief Director shall appoint a supervisor of the medical relief program of the county, preferably a physician, who shall be em-

ployed on a full or part-time basis and whose compensation shall be fixed by the local relief director to be paid out of the administrative funds of the local relief administration.

"Such supervisor shall be selected by the local relief director from a list of qualified persons submitted to him by the local medical advisory committee. He shall serve at the pleasure of the local relief director and be responsible to him at all times.

"The supervisor shall be the contact agent between the local relief administration and the various professional groups rendering service to those on the relief rolls. He shall, with the consent of the local relief director, issue authorizations for professional service, medicine and medical supplies, and check and pass upon all bills for such services and supplies.

"The supervisor shall confer with the local medical advisory committee frequently to obtain its advice on administrative and professional problems and solicit its cooperation on all activities carried on as a part of the medical program.

"The supervisor shall not be permitted to render professional service to those on relief."

SPECIAL TREATMENTS; SPECIAL DRUGS

8. Modification of the present regulations pertaining to special treatments was suggested, making it mandatory that special treatments shall be authorized only on the recommendation of the attending physician, following the submission of evidence by him as to the necessity for such assistance and consultation between the local relief director and the local medical advisory committee.

9. Changes in the regulations pertaining to special drugs and medical supplies were recommended, designed to minimize their use. The following sections were recommended for insertion in the regulations:

"The physician shall make request for SECIALIST, NURSE, SPECIAL DRUGS, or SUPPLIES to the local relief administration in writing, by telephone, or verbally, submitting evidence of the need for such. If the request is granted, the authorization agent shall make out a Form SRC 729, encumbering the funds. A record of the authorization shall be made on Form RM or Form RO by the physician. No bills for Special Drugs or Supplies shall be honored except those purchased upon the request of a physician and the purchase of which has been authorized by the local relief administration.

"Physicians shall use a formulary which excludes expensive drugs where less expensive drugs can be used with the same therapeutic effect. Special drugs and medicine shall be restricted to the National Formulary or the United States Pharmacopeia. No special drugs and supplies shall be dispensed without the authorization of the local relief administration. Prescriptions for special drugs, supplies, appliances, etc., must be approved by the local relief administration before being presented to a pharmacist for filling. To avoid excessive expenditures for remedies of unknown or doubtful value, proprietary or patent medicines shall not be authorized. In disputed cases involving requests for authorization to dispense or prescribe special drugs and medical supplies, the local relief director (medical supervisor or authorization agent) shall consult with the local medical advisory committee."

NEW FINANCING PLAN PROPOSED

10. An entirely new set-up for the allocation and distribution of funds for medical care was recommended. It would provide for the distribution of unexpended balances to counties where maximum funds allocated for medical service had proven insufficient and for the payment of bills for special drugs and special medical supplies from direct relief funds other than those encumbered for professional services. The following section was suggested for insertion in the regulations:

"Funds to defray the cost of medical, dental and nursing services in each county be withheld by the State Relief Administration each month from the amount allocated to the county for direct relief and encumbered to meet bills for authorized services incurred by the county during the month.

"The total of the funds encumbered for such purposes in each county in the months of November, December, January, February, March and April shall not be less than an amount equal to $1.25 per family and $.25 per single person on the relief rolls of the county for the month and in May, June, July, August, September and October, not less than an amount equal to $1.00 per family and $.20 per single person.

"Bills for medical, dental and nursing services approved by the local relief administration shall be certified to the State Relief Administration on the last of each month for the previous month and be paid from the respective county fund encumbered for such purposes on or before the 10th of the following month.

"Unexpended balances accruing after bills for such services for the month have been paid, shall be transferred by the State Relief Administration to a special fund to be known as the "Medical Emergency Fund". Withdrawals from such fund may be made by order of the State Relief Administration and allocated to individual counties in event of epidemics, unusual emergencies, etc., and upon submission of substantial evidence that the usual budgetary allowance for medical, dental and nursing services was insufficient to meet the actual monthly medical needs of the county.

(NOTE: If the procedure suggested in the foregoing paragraph cannot be carried out because of accounting regulations of the Federal

Emergency Relief Administration, it is suggested that consideration be given to the following substitute paragraph):

("Unexpended balances in the funds encumbered for counties where the amount encumbered exceeds the total bills for professional services during the month may be distributed by the State Relief Administration among those counties where the fund encumbered was insufficient to meet bills for necessary medical, dental and nursing services, following the submission of evidence that the medical needs of the county for the month were extraordinary because of an emergency or epidemic.")

"If the total monthly expenditures for medical, dental and nursing services in a county exceeds the total amount encumbered for the county, bills for such services shall be pro-rated, except under conditions as specified in the preceding paragraph.

"Bills for special drugs, supplies, appliances, etc., purchased by the county relief administration for relief patients, or dispensed or prescribed by physicians upon authorization, shall be paid by the local relief administration from funds allocated to the county for direct relief and not from funds encumbered by the State Relief Administration for professional services. The local relief administration shall make trade agreements, if possible, with pharmaceutical organizations and druggists for uniform or reduced rates for prescriptions and special supplies or appliances."

11. Changes in sections of the regulations pertaining to encumbering procedure, forms, etc., were suggested to make these procedures conform to changes suggested in other sections of the rules and regulations.

In addition to the foregoing recommendations, the Policy Committee also submitted to Mr. Stillman an appended report commenting on various aspects of the medical relief program and incorporating information obtained from questionnaires returned by the officers of approximately 70 of the county medical societies and academies of the state and from correspondence with officials of other states.

ADDITIONAL COMMENTS PRESENTED

Some of the more important points discussed in the appendix were:

1. *Rotating, Salaried Physician Plan.* Commenting on this plan in effect in one county, the Policy Committee said: "There is much to be said for this plan. At the same time, the Policy Committee believes that this plan would not be adaptable to all counties, especially the larger urban centers and distinctly rural counties. For that reason we are of the opinion that the mechanics for such a plan should not be included in the standing Rules and Regulations. We suggest that the State Relief Administration might, on request, give its approval to the inauguration of such a plan in any county where it would be applicable and where such an arrangement might be worked out by the local relief director and the county medical society."

2. *Financing of Medical Care.* The committee emphatically requested the State Relief Administration to give serious consideration to the recommendation that bills for special drugs, special medical supplies, etc., be paid from funds other than those available for professional services and that provision be made for special appropriations to counties where because of epidemics or emergencies the regular allowance for medical, dental and nursing services prove insufficient and prorating is found necessary. It was pointed out that these points should be considered in any financing plan the administration may decide upon. The committee also suggested as an alternative plan that perhaps counties might be divided into groups according to the usual costs of medical service and allocations made on a group basis.

3. *Medical Supervision on a District Basis.* It was stated it had been suggested to the committee that counties be grouped into districts and a medical supervisor, who would be a physician, be appointed for each district; be paid a monthly salary; and be responsible to the State Relief Administration in supervising the medical program of his district.

CHECK ON SPECIAL SERVICES

4. *Special Services.* On this subject, the committee declared:

"We are of the opinion that the Rules and Regulations as revised by this committee provide an adequate check on expenditures for special treatments, special drugs, special appliances, etc., if there is proper local administration and frequent conferences between the local relief director (and his agents) and the local advisory committees.

"The Rules and Regulations in some states include detailed instructions on this question. One state outlines in detail how and under what conditions glasses may be purchased for relief clients. Information submitted to us would seem to indicate that refraction is being authorized in many instances when there is no sound reason why the relief client should have his eyes examined.

"One state lists by name special drugs and supplies which may be prescribed or dispensed. Information secured by the committee indicates that in some counties the purchase of merchandise sold by drug stores has been authorized and carried on the books as "special drugs and supplies".

"The revised Rules and Regulations applying to these items should be strictly enforced and we believe they are sufficiently clear and complete to meet most situations that might arise."

5. *Advisory Committees.* In amplification of its request that a practical system of local medical

advisory committees be inaugurated, the committee said:

"Information secured from other states indicates that professional advisory committees have been used to a good advantage. In some states the state medical advisory committee works quite closely with the state medical supervisor and is given definite responsibilities. The same is true of the local advisory committees in some of the other states.

"We sincerely hope that a system of medical advisory committees can be inaugurated in Ohio. If given a chance to function and delegated definite responsibilities, we believe such advisory committees would be of material assistance to the relief directors in keeping medical expenditures within reasonable limitations."

6. *Greater Use of Nurses.* It was suggested that the employment of one or more nurses to assist in the medical program in each county be encouraged. The committee voiced the opinion that a nurse could be used to good advantage in investigation of cases and in follow-up work, not to render medical care but to secure information for the local relief administration.

PRENATAL AND POSTNATAL VISITS

7. *Prenatal and Postnatal Visits.* Some criticism has been raised relative to the limited number of prenatal and postnatal visits, the committee pointed out. No changes in the regulations were suggested for the reason that most situations requiring a greater number of visits of this character can be handled by the local relief administration upon the submission of adequate evidence of the need for more visits and frequent conferences with the local medical advisory committee merely by special authorizations to the attending physician.

8. *Hospitalization.* On this important subject, the committee said:

"It is realized that the Federal Regulations specifically prohibit the expenditure of Federal Funds for hospitalization. At the same time, there is at the present time in many counties in Ohio the need for some provision for the care of relief patients with disabilities requiring hospital care. It is suggested that the State Relief Administration do everything possible to bring pressure to bear upon local officials to make some provision for hospitalization."

9. *Forms and Records.* It was suggested that a study be made of the present paper work required of physicians for the purpose of simplifying it, if at all possible. Physicians and others should be required to submit necessary and pertinent data but should not be unnecessarily burdened in this respect, the committee said.

DISCIPLINARY ACTION RECOMMENDED

10. *Unnecessary Calls.* On this subject, the appendix presented to Mr. Stillman stated:

"Many of the questionnaires returned to the committee state that too frequently a physician is summoned by a relief client for trivial disabilities which in many instances do not necessarily require the services of a physician. It is suggested that the local relief office in each county through its case workers, etc., make additional efforts to impress on relief clients that medical service should not be requested except in cases of actual necessity. Persons who persistently abuse the provisions for medical care to those on relief should be subjected to disciplinary action by the local relief administration.

"Also, we recommend that disciplinary action be taken against physicians, dentists, nurses and pharmacists found guilty of abuses."

11. *Delay in Obtaining Authorizations.* The State Relief Administration was requested to call to the attention of all local relief directors the importance of promptness in issuing authorizations for necessary medical care.

12. *Mileage Allowances.* The committee recommended that a study be made to determine if the mileage allowance is sufficient. It was pointed out that criticism from rural districts had been received by the committee and that perhaps adjustments should be made.

—OSMJ—

Licensed Through Reciprocity

Licenses through reciprocity to practice medicine and surgery in Ohio have been issued to the following by the State Medical Board: Dr. Joseph R. Bowman, Cincinnati, Vanderbilt University; Dr. Ernest F. Bright, Cleveland Heights, Harvard Medical College; Dr. Leora P. Dahlgren, Carrollton, Medical College of South Carolina; Dr. Lester L. Eberhart, Bryan, Indiana University; Dr. Leslie P. Haefele, Cleveland, Wayne University; Dr. Joseph J. Hohner, Steubenville, Creighton University; Dr. Charles B. Horton, Dayton, University of Toronto; Dr. Peter G. Kroll, Hendrysburg, Medical College of South Carolina; Dr. Henry Lee, Cincinnati, Johns Hopkins University; Dr. Elizabeth A. Leggett, Kent, University of Minnesota; Dr. Crawford E. McLain, Cleveland, Emory University; Dr. Robert E. Odom, Youngstown, University of Virginia; Dr. Ernest J. Oesterlin, Springfield, Vienna University; Dr. Robert B. Palmer, Cleveland, University of Texas; Dr. Louis Pillersdorf, Cleveland, University of Louisville; Dr. John W. Post, Medina, Temple University; Dr. Bert R. Richey, Toledo, State University of Iowa; Dr. Henry C. Shaw, Cleveland, Washington University; Dr. Alexander H. Sneddon, Lore City, Jefferson Medical College; Dr. Homer B. Thomas, Gallipolis, State University of Iowa; Dr. William C. D. McCuskey, Steubenville, Jefferson Medical College and Dr. Wilmot W. Peirce, Mansfield, Johns Hopkins University.

HOTEL RESERVATIONS SHOULD BE MADE PROMPTLY FOR 89TH ANNUAL MEETING, CINCINNATI, OCT. 2, 3 AND 4

HOTEL reservations should be made in the near future by members of the Ohio State Medical Association who are planning to attend the 89th Annual Meeting at Cincinnati, Wednesday, Thursday and Friday, October 2, 3 and 4.

The Netherland Plaza, Cincinnati's newest hotel and one of the finest in the country, has been designated as the headquarters hotel. It will house the commercial and scientific exhibits, and will be the meeting place for all the general and scientific sessions.

Cincinnati has many fine hotels with splendid accommodations, but members should not delay making reservations, if they expect to get the type of room desired.

Requests for reservations *should be made direct* to the management of the hotel selected, and verification of the reservation requested.

Following is a list of Cincinnati hotels, their rates and conveniences:

NETHERLAND PLAZA

Headquarters Hotel

800 rooms, with bath; single room, $3.00 to $6.00; double room, $5.00 to $8.00.

HOTEL GIBSON

1000 rooms, with bath; single room, $2.50 to $4.00; double room, double bed $4.00 and $5.00; double room, with twin beds $5.00 and $6.00.

SINTON-ST. NICHOLAS

750 rooms, with bath; single rooms, $2.00 and up; double rooms, double bed $3.00 and up; double rooms, twin beds, $4.00 per day and up; suites, consisting of bedroom, parlor, reception hall and two baths, $6.00 per day and up single; $8.00 per day and up, double.

HOTEL METROPOLE

400 rooms, with bath; single rooms, $2.00 and $2.50; double rooms, $3.00, $3.50 and $4.00.

HOTEL ALMS

500 rooms with bath; single room, $3.00; double room, $5.00; two-room suite, $7.50.

FOUNTAIN SQUARE HOTEL

250 rooms with bath; single room, $2.00 to $3.00; double room, $3.00 to $4.50.

HOTEL HAVLIN

180 rooms; single room with bath, $2.00; double room with bath, $2.50; double room, with twin beds and bath, $3.00.

Annual Reunion of Cincinnati U. Medical Alumni to Be June 8

The Annual Reunion and Homecoming of the College of Medicine, University of Cincinnati, will be held on Saturday, June 8, at Cincinnati. The guest of honor and chief speaker at the banquet on Saturday night will be Dr. Marion A. Blankenhorn of Cleveland. Dr. Blankenhorn becomes head of the Department of Internal Medicine at the Medical College, University of Cincinnati, on September 1. Dr. Ben L. Bryant, president of the Alumni Association, will preside at the banquet.

An excellent program of papers and clinics has been scheduled on Saturday morning. Dr. Robert A. Kehoe will speak on "Lead Poisoning With Special Reference to Laboratory Diagnosis". Dr. George Guest's topic is "The Anaemias of Early Childhood". Dr. William Miller will speak on "The Newer Aspects of Radium Therapy in the Management of Malignant Disease", and Dr. Johnson McGuire on "Some Pertinent Questions in Electrocardiography". Luncheon will be held at the College of Medicine at 12:15.

The afternoon will be devoted to a series of round table discussions which will begin at 2:00 p. m. "Recent Advances in Haematology" will be discussed by Dr. Leon Schiff. "The Diagnosis and Treatment of Diseases of the Biliary Tract and Pancreas" will be discussed by Dr. Max Zinninger, and "Peripheral Vascular Disease", by Dean Alfred Friedlander and Dr. Louis Herrmann.

All graduates of the Medical College of Ohio, Miami Medical College and the Medical College of the University of Cincinnati will be cordially welcomed at Cincinnati on Saturday, June 8.

The committee on arrangements is composed of: Drs. Ben Bryant, Alfred Friedlander, Robert Lyon, Helena Ratterman, S. E. Dorst, Donald Lyle, Fred Heinold, Willard Machle, Richard Weiskittel, William Doughty, L. G. Herrmann, Frank B. Cross, J. S. Mathews, Carl A. Wilzbach, Martin H. Fischer, E. W. Mitchell, Samuel Zielonka.

—OSMJ—

Ohio Alumni Plan Meeting

The Ohio State Alumni Dinner is to be held June 12th, 6:30 P. M., at the Ambassador Hotel, Atlantic City, during the annual session of the American Medical Association, June 10-14.

OHIO PHYSICIANS WILL HAVE PROMINENT PART IN ANNUAL SESSION OF A. M. A., JUNE 10-14, AT ATLANTIC CITY

MANY Ohio physicians undoubtedly will attend the Eighty-Sixth Annual Session of the American Medical Association at Atlantic City, June 10-14. For the first time in history, this is a joint session with the Canadian Medical Association.

The opening session will be at 10:00 A.M., Monday, June 10, when the House of Delegates convenes at the Ambassador Hotel, the headquarters hotel. The Scientific Assembly will open with a general meeting to be held at 8:00 P.M., Tuesday, June 11. The sections will meet Wednesday, Thursday and Friday, June 12, 13 and 14. All the scientific meetings, scientific exhibit, registration bureau and the technical exhibit will be at the Convention Hall.

The usual special railroad rates have been granted members of the A.M.A. and dependent members of their families who attend the session. To have the benefit of a return rate of one-third fare, it will be necessary for each member to secure a certificate from the railroad ticket agent from whom he purchases his ticket to Atlantic City.

A complete program of the A.M.A. session and data concerning railroad rates and hotel accommodations were published in the May 11 issue of *The Journal of the American Medical Association.*

The Ohio State Medical Association will be represented in the House of Delegates by Drs. J. P. DeWitt, Canton; C. E. Kiely, Cincinnati; C. W. Waggoner, Toledo; Wells Teachnor, Sr., Columbus; Ben R. McClellan, Xenia; E. R. Brush, Zanesville, and C. W. Stone, Cleveland.

A prominent part in the meeting of the House of Delegates and the business sessions will be taken by Dr. J. H. J. Upham, Columbus, chairman of the Board of Trustees of the A.M.A., and Dr. Geo. Edw. Follansbee, Cleveland, chairman of the Judicial Council.

Other A.M.A. officials from Ohio who are expected to take part in the session are Dr. Torald Sollmann, Cleveland, member of the Council on Pharmacy and Chemistry, and Dr. Howard T. Karsner, Cleveland, member of the Council on Physical Therapy.

The following Ohio physicians are officers of scientific sections: Dr. M. A. Blankenhorn, Cleveland, vice-chairman of the Section on Practice of Medicine; Dr. Robert S. Dinsmore, Jr., Cleveland, vice-chairman of the Section on Surgery, General and Abdominal; Dr. Arthur J. Skeel, Cleveland, vice-chairman of the Section on Obstetrics, Gynecology and Abdominal Surgery; Dr. A. Graeme Mitchell, Cincinnati, chairman, Section on Pediatrics; Dr. Russell L. Haden, Cleveland, secretary of the Section on Pharmacology and Therapeutics; Dr. James R. Driver, Cleveland, vice-chairman of the Section on Dermatology and Syphilology; Dr. Harry L. Rockwood, Shaker Heights, vice-chairman of the Section on Preventive and Industrial Medicine and Public Health; Dr. John T. Murphy, Toledo, secretary of the Section on Radiology; Dr. Thomas P. Shupe, Cleveland, vice-chairman of the Section on Urology, and Dr. Bernard H. Nichols, Cleveland, vice-chairman of the Section on Radiology.

Others from Ohio who will take part in the Atlantic City meeting as essayists, discussants, or scientific exhibitors are: Dr. Henry J. John, Cleveland; Dr. George W. Crile, Cleveland; Dr. C. A. Doan, Columbus; Dr. G. M. Curtis, Columbus; Dr. B. K. Wiseman, Columbus; Dr. Arthur M. Culler, Dayton; Dr. Walter M. Simpson, Dayton; Dr. B. S. Kline, Cleveland; Dr. John A. Toomey, Cleveland; Dr. William E. Lower, Cleveland; Dr. Roy McCullagh, Cleveland; Dr. Tom D. Spies, Cleveland; Dr. E. Perry McCullagh, Cleveland; Dr. Harold N. Cole, Cleveland; Dr. E. A. Levin, Cleveland; Dr. Clarence L. Hyde, Akron; Dr. Carl R. Steinke, Akron; Dr. William E. Brogden, Canton; Dr. G. I. Bauman, Cleveland; Dr. Ralph G. Carothers, Cincinnati; Dr. Albert D. Ruedemann, Cleveland; Dr. V. Seitz, Cleveland; Dr. W. Kenneth Cuyler, Cleveland; Dr. Milton B. Cohen, Cleveland; Dr. A. M. Young, Cleveland; Dr. Clyde L. Cummer, Cleveland; Dr. Charles G. LaRocco, Cleveland; Dr. John S. Lewis, Jr., Youngstown; Dr. Edgar C. Baker, Youngstown; Dr. C. C. Higgins, Cleveland; Dr. Wallace S. Duncan, Cleveland; Dr. Thomas E. Jones, Cleveland; Dr. Louis G. Herrmann, Cincinnati; Dr. E. J. McGrath, Cincinnati; Dr. Derrick T. Vail, Jr., Cincinnati, Dr. D. E. Jackson, Cincinnati; Dr. Walter G. Stern, Cleveland; Dr. Louis E. Papurt, Cleveland; Dr. Clarence H. Heyman, Cleveland.

Entertainment of the visiting physicians has been well provided for. A dinner and entertainment in the Submarine Grill of the Traymore Hotel for delegates and officers of the American Medical Association and of the Canadian Medical Association is being arranged for Monday, June 10, from 7 to 11 P.M. A luncheon for officers and the House of Delegates of the A.M.A. will be held Tuesday noon, June 11, at the Ambassador Hotel. A special entertainment and informal dance will be held on the Steel Pier, Wednesday evening, June 12. On the same evening the Medical Veterans of the World War will hold a meeting. The President's Reception and Ball will be Thursday evening, June 13, at the Ambassador Hotel. Attention of Ohio State alumni is especially called to the annual dinner scheduled for 6:30 P. M., June 12.

ALAMEDA COUNTY (CALIF.) PLAN PROVIDES UNIQUE METHOD OF PROVIDING LOW INCOME CLASSES WITH MEDICAL CARE

IN compliance with its intention to give to the membership of the Ohio State Medical Association information regarding some of the experimental plans in operation in various parts of the country to provide medical care for the low income groups on a somewhat different basis than that commonly known as the direct patient-physician relationship, *The Journal* presents the following analysis of the so-called Alameda County (California) Plan, made by the Bureau of Medical Economics of the American Medical Association. As was pointed out some months ago (March, 1935, issue) in connection with a summary of the widely-discussed Wayne County (Detroit) Plan, various plans now underway should be studied carefully by the medical profession inasmuch as they may suggest a solution to local problems in many other communities.

BEFORE any plan was adopted, the Alameda County Medical Association undertook a study to determine the best method of providing medical care for three classes of the population: (1) the indigent, (2) the individual of moderate means, and (3) those who can properly finance their medical care.

Various clinics and other institutions supplying medical care were already operating in Alameda County with little cooperation and no coordinating body. In 1917 the county board of supervisors established the Alameda County Institutions Commission for the purpose of taking entire charge of all county institutions wholly supported by county funds and designed for the care of the indigent sick.

In 1930, when the problems of medical care became more acute, another survey was made. The report of this survey recommended that all indigents be referred to clinics operated by the County Institutions Commission, or to county physicians, who were regular salaried employes on a part-time basis. All pay clinics were abolished.

OFFICIAL ACTION TAKEN

These changes left in the hands of the Alameda County Medical Association the problem of caring for the low income group, who, in the new arrangement, were left without medical care. After an extensive investigation, the association adopted the following resolution in October, 1932:

Resolved, That it appears to be necessary to establish a plan whereby certain patients formerly cared for at health centers, who do not technically fall under the term "indigency" and at the same time require attention at the hands of reputable physicians, and whose care should be assumed at a fair price within the ability of the patient to pay; and be it further

Resolved, That the Alameda County medical Association agrees to establish a list of physicians who will volunteer to accept calls for such classes of patients and to render service when called in cooperation with the established official county agencies and centralized social service, as established in Alameda County and according to such additional plans as may be adopted.

The call for volunteers to cooperate in carrying out the plan met with practically 100 per cent response from the members of the association.

Arrangements were then made for a cooperative plan by the medical association and the County Institutions Commission. Members of the medical association agreed to treat nonindigent patients privately for whatever fee they were able to pay, provided their ability to pay could be determined by the County Medical Social Service, and provided any necessary social work could be rendered by medical social workers of the clinics.

CAREFUL INVESTIGATIONS MADE

"The Social Service Department of the County Institutions Commission is responsible for contributing the following types of assistance to physicians participating in the plan:

"*(a)* Social study (economic situation, home and work environment, habits and attitudes of patients and family which may have a bearing upon the medical problem).

"*(b)* Medical Social Case Work (aiding the patient or his family to meet social problems related to his illness, and mobilizing the resources of the community to make possible the carrying out of medical treatment).

"*(c)* Determination of the patient's ability to pay for medical care. The Social Worker's chief contributions here are:

(1) Securing adequate data regarding financial status of patient and family.
(2) Evaluating this in terms of the social and medical need of the patient.
(3) Assisting patient and family to develop an attitude of willingness to pay for medical care, and aiding them to develop resources for payment within their means.
(4) Securing relevant information from other agencies who have known the patients.

Recommendations as to fees patients can pay naturally become a by-product of the above investigation.

"The Medical Worker has the following relationship to any business agency established for the purpose of credit rating:

"*(a)* She can give a professional opinion as to the patient's financial resources, and his attitude of cooperation with the physician.

"*(b)* She cannot take the place of the credit agency in investigation of the patient's past records as to credit rating, and the risks involved in extending credit to him."

MECHANICS OF PLAN OUTLINED

When a call for service is made at any of the county institutions, the social service department ascertains whether the patient is already receiving relief and, if so, or if known to be indigent, the patient is referred to county physicians.

"If the patient's financial status is unknown or if he is known to be able to pay something for a home visit, the worker explains that a private physician will be sent and that the physician will discuss with him the matter of payment.

"The worker then refers the call by telephone to the next physician on the rotating list, giving him the data for Section A and B of Form 2538. She stamps the date on the physician's card and places the card at the end of the list. She records this call on the 'Report of Patients Referred to Private Physicians.' In case the first physician called cannot go, she continues down the list until she finds a physician who can make the call."

The physician makes at least one visit and renders the necessary service regardless of the patient's ability to pay any part of his fee. He then fills out a form giving certain social information and sends this to the social service department, which notifies the local clinic if a social investigator is requested by the physician.

REFERRED TO PRIVATE PHYSICIAN

Part-pay patients are referred to private physicians only after their financial status is known, and in accordance with the following procedure:

1. The social worker who has investigated the patient secures the name of the next physician on the list from the worker in that agency who keeps the list. The latter is responsible for stamping the date on the physician's card and records the referral on the "Report of Patients Referred to Private Physicians."
2. The social worker discusses with the patient the matter of payment and an understanding of the amount to be paid is arrived at before the case is referred to the private physician. The patient is also told that he will be expected to pay cash.
3. The social worker secures from the patient the signed consent for transfer of information and files this with the social face sheet.
4. She communicates with the private physician and arranges an appointment for the patient.
5. The patient is given a Refer Slip signed by the worker, on which is recorded the name and address of the physician and the date and hour of the appointment.
6. The social worker is responsible for sending to the physician any medical or social data, contained in the clinic records, which might be helpful to him in treating the patient.
7. The case is then closed at the clinic for that complaint, and considered a private patient until such time as the physician may refer it back, or until some other medical condition arises for which the patient cannot afford private care.

It is understood that the physician may request and receive assistance from the clinic social worker at any time.

Full pay patients are referred to the Secretary of the Alameda County Medical Association, for names of physicians from her own list.

STATISTICS FOR 1933

During the year 1933, 2,077 referrals to private physicians were made by social workers, clerks, nurses, doctors and others in the Alameda County agencies. These referrals were made to the three groups of physicians listed in table 1: *(a)* those who were members of the Alameda County Medical Association and had agreed to take patients at reduced fees; *(b)* those who were not members of the Alameda County Medical Association and whose names, therefore, were not on the list; *(c)* referrals made to the secretary of the Alameda County Medical Association with the understanding that the patients could pay a full fee.

TABLE 1.—*Distribution of Referrals, for Medical Services Under the Alameda County Plan, Made to Physicians in the County in 1933*

	Number	Per Cent
Total Referrals	2,077	100.0
To County Medical Association	1,898	91.3
To Co. Med. Asso.	1,898	100
For Part-pay care	1,812	95
For Full-pay care	56	5
To Physicians not on list	158	6.5
To Physicians, names not given	51	2.2

Of the total number of referrals made, 1,898, or 91.3 per cent, were made to physicians of the Alameda County Medical Association; only 158, or 6.5 per cent, were made to physicians not on the list; the remaining 2.2 per cent of the referrals were to physicians whose names were not stated but who might possibly have been members of the Association.

Of the 1,898 referred to the medical association, 95 per cent, or 1,812 referrals, were for part-pay medical care, and 5 per cent, or 56 referrals, were for full-pay medical care.

The following study has been made of the results of the first year's referrals:

Questionnaires were sent, March 1, 1934, to the 400 physicians whose names were on the part-pay lists and who were members of the Alameda County Medical Association. Information was re-

quested on only the 1,812 cases referred for part-pay care.

Returns were received from 279 doctors, or 70 per cent of the number to whom questionnaires were sent. These returns gave information about 1,304 referrals, or 71.96 per cent of the referrals about whom information was desired.

TABLE 2.—*Patients Actually Seen*

	Number	Per Cent
Total number about whom information has been received..	1,304	100
Patients seen by doctor.....	969	74.3
Patients not seen.....	335	25.7

The table shows that, of the 1,304 patients about whom some information was received, 969, or 74.3 per cent, were actually seen by various physicians, and 335, or 25.7 per cent, were not seen by the doctors to whom they had been referred.

Of the 969 patients seen, table 3 shows the percentage and the number of patients who paid no fees.

TABLE 3—*Number of Patients Paying Fees*

	Number	Per Cent
Total number of patients seen.....	969	100
Patients pay fees.....	736	76.
Patients paying nothing in fees.....	233	24.

It can be seen from this table that 76 per cent of the patients actually seen paid something for their medical services, while only 24 per cent paid nothing. A complete study of the amounts received from these 736 patients has not yet been made, but the total is slightly over $5,000.

—OSMJ—

Splendid Program Presented at Well-Attended Fifth District Meeting

The annual meeting of the Fifth District of the Ohio State Medical Association was held at the Allen Memorial Medical Library, Cleveland, Friday, May 17, with a large attendance from the counties in the district.

Dr. J. L. Reycraft, Cleveland, opened the morning session with a paper on "The Treatment of Toxemia of Pregnancy and Eclampsia".

"Treatment of the More Common Fractures", was discussed by Dr. Russell H. Birge, Cleveland, and Dr. H. C. King, Cleveland, concluded the morning session with a talk on "Management of Hypertension".

Following the Organization Luncheon, the program was resumed by Dr. C. L. Cummer, Cleveland, who spoke on "Diagnosis and Treatment of the More Common Skin Diseases". Dr. R. S. Dinsmore, Cleveland, discussed "Management of Peritonitis". "The Treatment of the Chronic Dyspeptic" was the subject of a paper presented by Dr. V. C. Rowland, Cleveland.

The second afternoon session was opened by Dr. A. Strauss, Cleveland, who discussed "The Treatment of Cancer of the Breast". Dr. J. A. Toomey, Cleveland, spoke on "Immunization in Childhood". The afternoon session was concluded by Dr. Russell Haden, Cleveland, with a talk on "Agranulocytosis, Its Prevention and Treatment".

The Brush Foundation had a special exhibit in the dining room of the Allen Memorial Medical Library on "The *X*-Ray Determination of Growth".

A special subscription dinner in honor of Dr. Francis M. Rackemann, Boston, and Dr. John A. Caldwell, Cincinnati, President of the Ohio State Medical Association, was held at Wade Park Manor prior to the evening meeting. Dr. Rackemann, a member of the staff in the department of internal medicine at Harvard Medical School, was the principal speaker at the evening session. He discussed the "Role of Allergy in General Medicine". Dr. Lester Taylor, President of the Cleveland Academy, gave the introduction and welcome at the evening meeting. Dr. Caldwell discussed organization problems.

—OSMJ—

American-Canadian Medical Golfers Play June 10th

International golf will be played at Atlantic City on June 10th when members of the American Medical Golfing Association and golf enthusiasts of the Canadian Medical Association join forces at Northfield Country Club.

The A.M.G.A.'s invitation to the Canadian Medical Association to hold a joint tournament this year has been accepted by Dr. T. C. Routley, General Secretary of the C.M.A.

Two additional events will be added to the day's already generous program of nine events and seventy prizes:

1. The International Event, featuring the "President's Cup," a new trophy presented by Dr. Chas. Lukens of Toledo, and nine other American prizes for our Canadian friends to carry back home.

2. The Canadian Event, featuring the "Ontario Cup," or championship trophy, and the other prizes of the Canadian Medical Association.

—OSMJ—

The First Annual Meeting of the American Neisserian Medical Society will be held at the Hotel Claridge, Atlantic City, N. J., June 11.

—OSMJ—

The Eighth Annual Graduate Fortnight of the New York Academy of Medicine will be held October 21 to November 2 and will be devoted to a consideration of "Diseases of the Respiratory Tract". A complete program and registration blank may be obtained by addressing Dr. Frederick P. Reynolds, the New York Academy of Medicine, 2 East 103d Street, New York City.

COUNTY SOCIETIES *and* ACADEMIES

First District

ACADEMY OF MEDICINE OF CINCINNATI

(H. J. Lavender, M.D., Secretary)

Meetings of the Academy held during May were as follows:

May 6—General Session. Program: "Some Observations on Diseases and Functions of the Small Intestines", by Dr. W. D. Hatch, Dean and Professor of Surgery, University of Indianapolis School of Medicine.

May 13—Case Reports: "Abdominal Pregnancy and Detailed Report of One Case", by Dr. James M. Pierce, with discussion by Dr. H. L. Woodward and Dr. J. D. Miller. "Total Urethrocystectomy in the Female—A Technique", by Dr. Henry B. Freiberg, with discussion by Dr. Joseph D. Heiman and Dr. Harry O. Lepsky. "Hemolytic Blood Transfusion Reaction with Oliguria", by Dr. Harvey G. McCandless, with discussion by Dr. Murray Rich.

May 20—General Session. Program: "Problems in the Digestive Field", by Dr. Thomas R. Brown, Associate Professor of Medicine, Johns Hopkins School of Medicine.

May 27—Annual Election of Officers.—Bulletin.

Adams County Medical Society met for its regular monthly meeting, Wednesday, April 17, at West Union. Dr. Clifford Foor, Hillsboro, addressed the Society on "Diseases of the Stomach and Duodenum and Their Treatment", (illustrated by moving pictures.) A motion picture, "The Science and Art of Obstetrics", prepared by Dr. Joseph B. DeLee, Chicago, was shown at the afternoon session, and Dr. Sam Clark, Cherry Fork, spoke on "Mumps".—Bulletin.

Butler County Medical Society held its regular monthly meeting at Hamilton, Wednesday afternoon, May 8. Dr. S. H. Rosen, Hamilton, was admitted to membership. Dr. J. I. Hofbauer, Cincinnati, spoke on "The Newer Aspects Concerning Etiology and Diagnosis of Carcinoma of the Uterus".—Vernon Roden, M.D., Secretary.

Clinton County Medical Society was addressed by Dr. Kelley Hale, Wilmington, on "Caesarean Section", at its regular monthly meeting, at Wilmington, Tuesday, May 6.—News Clipping.

Highland County Medical Society met at Hillsboro, for its regular monthly meeting, Wednesday, May 8, and was addressed by Dr. Martin L. Fischer on "Nature and Cause of Degenerative Diseases".—News Clipping.

Warren County Medical Society was addressed by Dr. Harry Huston, Dayton, on "The Acute Abdomen", at Lebanon, Tuesday, May 7.

Second District

Darke County Medical Society held its regular monthly meeting at Greenville, Friday, April 19. Dr. W. D. Bishop, Darke County health unit director, arranged the program, which featured a special motion picture exhibit depicting modern uses of anesthesia.—News Clipping.

Greene County Medical Society discussed the medical relief situation at its meeting at Xenia, May 2, but took no action pending result of negotiations of the State Association with the State Relief Administration. Dr. Tom Sharkey, Dayton, gave an interesting description of the difficulties in the care of diabetes and pregnancy. —R. R. McClellan, M.D., Secretary.

Clark County Medical Society met at Springfield, Thursday, May 9, at the Hotel Bancroft. The speaker was Dr. R. W. Kissane, Columbus, on "Traumatic Heart Disease".—News Clipping.

Miami County Medical Society met Friday, May 3, at West Milton. Dr. E. R. Arn, Dayton, gave an illustrated talk on "Surgery of the Malignancies of the Stomach and Colon".—News Clipping.

Montgomery County Medical Society held a meeting Friday, May 3, at the Van Cleve Hotel, Dayton. Dr. A. C. Furstenberg, talked on "Meniere's Disease".—News Clipping.

On May 17, at Stillwater Sanatorium, Dr. S. O. Freedlander, Assistant Professor of Surgery, Western Reserve School of Medicine, Cleveland, discussed "Surgery of Pulmonary Tuberculosis". —News Clipping.

A special meeting of the Society was held Tuesday, May 14, at Dayton, for the purpose of discussing the medical relief situation in the county.—Bulletin.

Preble County Medical Society was addressed by Dr. W. J. Millard, Cincinnati, on "The Use of Radium in Cancer", at a regular monthly meeting, Thursday, May 2, at Eaton.—News Clipping.

Third District

Allen County Medical Society met Thursday, April 18, at Lima. A clinic conducted by the staff of the Lima State Hospital for the Criminal Insane featured the meeting.—News Clipping.

Hancock County Medical Society held its regular monthly meeting at Findlay, Thursday, April 4. Dr. R. J. Semons, Carey, was accepted as a new member. Dr. D. M. Cowie, Professor of Infectious Diseases, University of Michigan, spoke on the newer things in pediatrics, illustrated by

motion pictures and lantern slides.—R. S. Rilling, M.D., Secretary.

Hardin County Medical Society met jointly with the nurses and dentists of the county, at Kenton, Thursday, April 18. The speakers were Dr. L. G. Hill, Toledo, on "Tooth Impaction", and Dr. F. W. Clement, Toledo, on "Anaesthesia".—News Clipping.

Logan County Medical Society met at Bellefontaine, Friday, April 12. An address was given by Dr. Daniel J. Kindel, Cincinnati, on "General Treatment of Syphilis", using illustrative lantern slides and motion pictures.—M. L. Pratt, M.D., Secretary.

Marion County Academy of Medicine was addressed Tuesday, May 7, at City Hospital, by Dr. Charles W. Stone, Professor of Neurology, Western Reserve University, on "Personality Tangents".—News Clipping.

Fourth District

TOLEDO ACADEMY OF MEDICINE

(F. C. Clifford, Secretary)

Programs for meetings of the Academy in May were as follows:

May 3—General Meeting. "The Interpretation of *X*-rays of the Chest with Special Reference to Childhood Tuberculosis"—Lantern Slide Demonstration. Dr. John A. Bigler, Children's Memorial Hospital, Chicago.

May 10—Section of Pathology, Experimental Medicine and Bacteriology. "Milestones in Medical Research", Sound Picture on the Production and Clinical Application of Insulin, Courtesy of Eli Lilly & Co., Indianapolis.

May 17—Medical Section. "The Medical Work of Life Insurance", Dr. Chester T. Brown, Medical Director, Prudential Life Insurance Company of America, Newark, N. J.

May 31—Eye, Ear, Nose and Throat Section. "Nasal Allergy, in Children, in the Adult, and its Relation to Sinus Infection and Asthma", Dr. Karl D. Figley, Discussants, Dr. E. G. Galbraith and Dr. L. A. Levison.

The Third Annual Post Graduate Clinic Day presented by the Department of Post Graduate Medicine of the University of Michigan for the Toledo Academy of Medicine was held at University Hospital, Ann Arbor, Michigan, Wednesday, May 22.—Bulletin.

Defiance County Medical Society met at the Defiance Hospital, Defiance, Tuesday, March 26. Dr. Byron G. Shaffer, Toledo, spoke on "The Surgical Treatment of Peptic Ulcer".

The April meeting of the Society was also held at the Defiance Hospital, Thursday, April 25, and was addressed by Dr. Bernhard Steinberg of Toledo, on "Vaccines", illustrated by lantern slides.—H. B. Wideman, M.D., Secretary.

Sandusky County Medical Society held a meeting at the City Hall, Fremont, Thursday evening, April 25. Medical care of indigent patients was discussed. Dr. R. A. Boice, Toledo, was the principal speaker.—News Clipping.

Wood County Medical Society was addressed by Dr. Norris W. Gillette, Toledo, on "New Developments in testing Thyroid Function", at its regular monthly meeting held Thursday, April 18, at Bowling Green, Ohio.—R. N. Whitehead, M.D., Secretary.

Fifth District

ACADEMY OF MEDICINE OF CLEVELAND

(Justin A. Garvin, M.D., Secretary)

Programs for meetings held during May were as follows:

May 3—Clinical and Pathological Section. "Two Cases of Meningococcic Septicemia with Recovery", Dr. C. T. Dolezal. "Aneurysm of Temporal Artery", Dr. J. V. Seids. "Block Neck Dissections for (a) Carotid Body Tumor, (b) Radiation Carcinoma Resection of Buttock for Lymphangiectasis", Dr. D. M. Glover, "(a) Cyst of Liver (b) Endo-Aneurysmorrhaphy of Femoral Aneurysm. (c) Excision of Arterio-Venous Aneurysm" (Demonstration of Cases), Dr. S. O. Freedlander. "Roentgen Therapy of Cancer" (Demonstration of Cases), Dr. Harry Hauser. "Cases of Ectopic Kidney", Dr. H. R. Trattner. "Pyelography in Congenital Polycystic Kidneys", Dr. D. A. Chambers. "Lympho-Granuloma of Vulva and Rectum", Dr. J. H. Lazzari. "Cyclic Menstrual Disorders in Adults", Dr. C. J. McDonald.

May 8—Practice of Medicine Section. "Correlation of Psychic and Somatic Disorders", Dr. Joseph Fetterman. "Cardiac Neuroses", Dr. J. P. Anderson. "Gastric Neuroses", Dr. I. H. Einsel.

May 10—Joint Meeting, Experimental Medicine Section and Cleveland Section of the Society for Experimental Biology and Medicine. "The Diagnostic Possibilities of the Rorschach Test", L. Dewey Anderson, Ph.D., and Marguerite R. Hertz, Ph.D. "Family Growth Patterns", Dr. Carl C. Francis. "Physical Features in Asia Minor, 4000 B.C., revealed by the Reserve Reconstruction of Skulls from Anatolia", Wilton Marion Krogman, Ph.D., and William H. Sassaman, M.A. "Facial Growth for Accommodation of the Permanent Incisor Teeth", (Moving Pictures), B. Holly Broadbent, D.D.S., F.A.C.D. "The Course of Aberrant Ossification in the Foot", Dr. Marion N. Gibbons, "The Age Order of Epiphyseal Closure in the Guinea Pig", Dr. Theodore T. Zuck.

May 15—Obstetrical and Gynecological Section. "Purpura Hemorrhagica Associated with Menorrhagia; Report of a Case", Dr. W. R. Barney. "Preliminary Report of a Recent Hemolytic Streptococcus Epidemic", Dr. C. A. O'Connell. "Occipito Posterior Presentations: Study of 1,000 cases", Dr. C. M. Speicher. (Discussion opened by Dr. C. T. Hemmings).

May 21—Military Medicine Section, "Exper-

iences of a Naval Surgeon", Lieut. C. M. Dunbar, U. S. N.—Bulletin.

Ashtabula County Medical Society met at the Hotel Ashtabula, Ashtabula, Tuesday, April 9. Dr. Fred Oldenburg of Charity Hospital, Cleveland, discussed "Some Problems of the Gastro-Intestinal Tract".—News Clipping.

Geauga County Medical Society met at Burton, Wednesday, May 1. Dr. W. A. Reed, formerly of Cleveland, was admitted to membership. On account of the incapacity of Dr. Lura E. Gordon, Dr. F. S. Basquin, Chardon, Vice-President, automatically succeeds to the presidency, and Dr. H. E. Shafer, was elected Vice-President.—Isa Teed Cramton, M.D., Secretary.

Medina County Medical Society met at Maukee Tavern, Seville, Thursday, April 8. Dr. C. L. Baskin, Akron, talked on "Common Skin Disorders and What to do for Them". Dr. L. E. Cullum, West Salem, a member of the Wayne County Medical Society was granted an associate membership in the Medina County Society.—News Clipping.

Dr. Claude Beck, Cleveland, addressed a meeting Wednesday, April 24, at Unionville, of the Tri-County Medical Society, which included physicians and their wives of Ashtabula, Lake and Geauga counties.

Sixth District

Mahoning County Medical Society held its eighth annual postgraduate day, at Youngstown, Thursday, April 25. The speakers were from Mayo Clinic and the University of Minnesota Postgraduate Medical School, and included Drs. Walter C. Alvarez, C. F. Dixon, Frank C. Mann and Henry W. Meyerding.—News Clipping.

Stark County Medical Society held an all-day meeting, Wednesday, May 15, at the Country Club, Alliance. Three members of the staff of Pittsburgh Diagnostic Clinic presented scientific papers. They were Dr. R. R. Snowden, internist, Chief of the Clinic; Dr. Sidney A. Chalfant, surgeon, and Dr. Robert Wright, psychiatrist.—News Clipping.

Summit County Medical Society meeting at the Mayflower Hotel, Akron, Tuesday, May 7, was addressed by Major H. N. Ervin, M.C.U.S.A., Fort Hayes, Columbus, on "The Medical Officers Reserve Corps", and by Dr. M. M. Hargraves, Assistant Director of Medical Research, Ohio State University, on "Fever Therapy—a Report of Recent Clinical and Investigative Progress". The Medical Round Table and Annual Guest Night of the Society was held at the Mayflower Hotel, Wednesday, May 15, and the following program presented: Dr. F. L. Sperry, Detroit, "Chronic Irritable Colon"; Dr. J. C. Maloney, Detroit, "Psychogenic Concepts of Migraine"; Dr. S. W. Wallace, Detroit, "Focal Infections in Relation to Systemic Diseases; Compliment Fixation as a Diagnostic Aid"; Dr. H. C. Walser, Detroit, "Asphyxia Neonatorium".—Bulletin.

Seventh District

Columbiana County Medical Society met April 9, at the American Legion Hall, Lisbon, and was addressed by Dr. George V. Foster of the United States Steel Corporation, Pittsburgh, on "Fractures and Their Treatment, Especially Those Involving the Lower Leg". The May meeting of the Society, held May 14, was addressed by Drs. William M. Skipp and W. K. Stewart, Youngstown, on "Medical Economics and the Federal Relief Plan as Functioning in Mahoning County".—Guy E. Byers, M.D., Secretary.

Coshocton County Medical Society held a meeting, Thursday, April 24, at the Coshocton City Hospital. Dr. H. O. Bratton, Columbus, spoke on "Prostatic Diseases".—News Clipping.

Jefferson County Medical Society was addressed at the Ohio Valley Hospital, Steubvenville, Tuesday, April 16, by Dr. H. R. Decker, Associate Professor of Surgery and Applied Anatomy, University of Pittsburgh, on "Modern Advances in Thoracic Surgery and Indications for Operative Treatment".—John Y. Bevan, M.D., Secretary.

Tuscarawas County Medical Society met Thursday, April 11, at Uhrichsville, and was addressed by Dr. A. J. Beams, Cleveland, on "The Diagnostic Significance of Indigestion". The May meeting of the Society was held at Dover on May 9. The speaker was Dr. Donald M. Glover, Cleveland, on "Injuries and Infections of the Hands and Feet". The Society is now publishing a monthly news bulletin to keep members informed of its activities.—Bulletin.

Eighth District

Athens County Medical Society met Monday, May 6, at the Athens State Hospital. Dr. C. S. Small, of the Hospital Staff, read a paper on "The Results of Malaria Treatment on Paresis".—News Clipping.

Fairfield County Medical Society was addressed by Dr. George T. Harding, III., Columbus, at a meeting held in Lancaster, Tuesday, April 10.—News Clipping.

Guernsey County Medical Society at a meeting at Cambridge, Thursday, April 4, went on record as being in favor of any funds to be spent by the Guernsey County Tuberculosis Association, or from any relief source in the diagnosis and treatment of tuberculosis, being turned over to the Guernsey county and Cambridge city boards of health to be administered as they think best. The Society felt that the creation of a new organization for this purpose would mean an overlapping of functions.—News Clipping.

At a joint meeting at Cambridge, Thursday, April 11, with the Guernsey County Dental and

Bar Associations, the Society was addressed by Judge Roy H. Williams, Sandusky, Judge of the Supreme Court of Ohio, on "The Problems Confronting Us".—News Clipping.

Muskingum County Academy of Medicine met Wednesday, May 1, in the University Club rooms, Zanesville. The speakers were Dr. I. W. Curtis, New Concord, on "Pneumonia", and Major Humphrey N. Ervin, M.C.U.S.A., on "The Need of the Medical Reserve Corps of the Army".—Bulletin.

Licking County Medical Society meeting at Newark, Friday, April 26, was addressed by Dr. Harold Jacox, Department of Roentgenology, University Hospital, Ann Arbor, Michigan, on "The Value of Radiation Therapy".—Geraldine H. Crocker, President.

Perry County Medical Society held its regular monthly meeting at the Park Hotel, New Lexington, Monday, April 15. Dr. W. B. Morrison, Columbus, spoke on "Lesions of the Gastro-Intestinal Tract".—News Clipping.

Ninth District

Hocking County Medical Society met Thursday, April 11, in the Ambrose Hotel, Logan. Dr. C. P. Swett, city health commissioner, discussed "Coronary Thrombosis".—News Clipping.

Scioto County—The regular monthly meeting of The Hempstead Academy of Medicine was held at the recreational hall, Nurses' Home, Portsmouth, Monday evening, May 13. The subject discussed by Dr. Tunis Nunemaker and Dr. Jackson Herbert was "Summer Diarrhoea".—Wm. E. Scaggs, M.D., Secretary.

Tenth District

COLUMBUS ACADEMY OF MEDICINE

(Drew L. Davies, M.D., Secretary)

May meetings of the Academy were as follows:

May 6—"The Treatment of Disturbances of the Cranial Nerves", illustrated with lantern slides, Dr. Walter E. Dandy, Professor of Neurological Surgery, Johns Hopkins University, Baltimore, Md.

May 13—"The Clinical Significance of Amyloidosis", illustrated with lantern slides, Dr. Louis E. Barron, Depts. of Medical and Surgical Research, Ohio State University College of Medicine. "Rat Bite Fever", Dr. Samuel D. Edelman. The experimental work presented in this paper was done in the Columbus Children's Hospital with the assistance of Dr. Gene Haber, formerly resident physician.

May 20—"Gastro-intestinal Atopy", Dr. Jonathan Forman. "The Failures in Management of Asthma", Dr. John Mitchell.

May 27—General Practitioners' Section. "The diagnosis of Gastro-Intestinal Disease purely from a Good History", Dr. Walter C. Alvarez, Mayo Clinic, Rochester, Minn.

Crawford County Medical Society met Monday, May 6, at the Bucyrus City Hospital. The speaker was Dr. Sterling H. Ashmun, Dayton, who discussed "The Prevention and Treatment of Communicable Diseases".—News Clipping.

Morrow County Medical Society held its regular monthly meeting Tuesday evening, May 14, at the Globe Hotel, Mt. Gilead. Dr. S. J. Goodman, Councilor of the Tenth District, gave a splendid talk on the "Toxemias of Pregnancy", and Dr. Eugene F. McCampbell talked on "Some newer developments in medicine". The program was an outstanding one and the meeting was well attended by the Mororw County Society and a large number of guests from surrounding counties.—T. Caris, M.D., Secretary.

Ross County Medical Society held its regular monthly meeting, Thursday, April 4, at Dun Glen Manor, Chillicothe. "Neurological Lesions", "Problems in Diagnosis", "Gastric Pathology", and "*X*-Ray Diagnosis", were the subjects discussed by Drs. F. W. Harrah and J. H. Warren, both of Columbus.—News Clipping.

—OSMJ—

Nurses Hold Convention in Toledo

The 32nd annual convention of the Ohio State Nurses' Association was held at Toledo, April 30 to May 4, with approximately 400 in attendance. Among the speakers and subjects presented were the following: Dr. Claude S. Beck, Lakeside Hospital, Cleveland, "Surgery of the Heart"; Dr. J. T. Murphy and Dr. Edward T. McCormick, Toledo, "Cancer and Its Treatment"; Dr. Joseph A. Muenzer, Toledo, "Recent Advances in the Treatment of Endocrine Disturbances"; Miss Frances Whitney, assistant director, Ohio State Employment Service, "Social Insurance"; Dr. Paul Holmes, Toledo, "Surgical Intervention in Tuberculosis".

Officers elected for 1935-1936 were: Miss Elsie Druggan, Athens, president; Miss Catharine Buckley, Cincinnati, first vice-president; Miss Celia Cranz, Akron, second vice-president; Mrs. Helen S. Haughton, Columbus, secretary; Miss Esther Brigga, Springfield, treasurer.

—OSMJ—

Dr. Reginald M. Atwater Appointed Executive Secretary

Dr. Eugene L. Bishop, President of the American Public Health Association, has announced the appointment of Reginald M. Atwater, M.D., Dr. P.H., as executive secretary of the Association. Dr. Atwater for the past eight years has been Commissioner of Health in Cattaraugus County, N. Y. Dr. Atwater, who is a native of Colorado, is a graduate of Colorado College and of the Harvard Medical School where he received his M.D. degree in 1918. He became a Rockefeller Foundation Fellow in Public Health and was granted the degree of Dr. P. H. by Johns Hopkins in 1921.

DEATHS IN OHIO

Samuel Shaw Crumbaugh, M.D., Toledo; Medical College of Ohio, Cincinnati, 1872; aged 87; died April 4 following an illness of several months. Dr. Crumbaugh practiced in Toledo for 35 years. He had been a Mason for nearly 60 years, and was first worshipful master of Calumet Lodge. He was a member of the Third Presbyterian Church. Surviving are one daughter, a son, Dr. Vernon Crumbaugh, and four grandchildren.

Frederick Foster Dowds, M.D., Mt. Vernon; Western Reserve University, School of Medicine, Cleveland, 1912; aged 53; former member of the Ohio State Medical Association and of the American Medical Association, died April 30, from apoplexy. Dr. Dowds had practiced in Mt. Vernon since completing his internship in Lakeside Hospital, Cleveland. He was physician at the Childrens' Home for 15 years and the Ohio State Sanatorium for one year. He is survived by his widow, one son, one daughter, his mother, and one brother and one sister.

Robert Lee Grimes, M.D., Urbana; College of Physicians and Surgeons, Baltimore, Md., 1890; aged 71; died April 17, after a long illness. Dr. Grimes practiced in Westerville for 40 years, retiring a few years ago to live in Urbana. He was a member of the Urbana Methodist Church. His widow, a brother and a sister survive him.

Joseph T. Kennedy, M.D., Cincinnati; Medical College of Ohio, Cincinnati; 1907; aged 51; former member of the Ohio State Medical Association and the American Medical Association; died April 30, of pneumonia. For 15 years Dr. Kennedy had been stationed at various United States veterans hospitals throughout the country in charge of neuro-psychiatric cases. He is survived by his widow, a son and a daughter, one brother and a sister.

Albert Harter Lane, M.D., Dayton; Louisville Medical College, Louisville, Ky., 1894; aged 79; member of the Ohio State Medical Association and a Fellow of the American Medical Association; died May 5. Dr. Lane practiced in Dayton for 44 years. He was a member of the Masonic Lodge, Dayton Council of Jr. O.U.A.M., Knights of Pythias, Odd Fellows, and the Euclid Avenue United Brethren Church. Surviving are his widow, a son, a daughter and a sister.

Wade W. Lawrence, M.D., Cambridge; Medical College of Ohio, Cincinnati, 1903; aged 56; former member of the Ohio State Medical Association and the American Medical Association; died April 23, of erysipelas. Dr. Lawrence practiced at Antrim until 1919, when he moved to Cambridge. Several years ago he was awarded a Carnegie medal for heroism for rescuing the superintendent of the local waterworks department from the ejector plant which was filled with deadly sewer gas. Dr. Lawrence was a member of the First United Presbyterian Church. He is survived by his widow, five daughters, one son, and his mother.

Jay S. McCulloch, M.D., Wellsville; Ohio Medical University, Columbus, 1904; aged 59; member of the Ohio State Medical Association and the American Medical Association; died April 24, from a heart attack. Dr. McCulloch had practiced in Wellsville for 30 years; served on the East Liverpool City Hospital staff, and for many years was surgeon for the Pennsylvania Railroad Company and the American Sheet and Tin Plate Company. He was a member of the Kiwanis Club and the Presbyterian Church, and was city health commissioner. Surviving are his widow, a son, a daughter and three brothers, one of whom is Dr. H. D. McCulloch, Toronto, Ohio.

Philip C. Marquart, M.D., Springfield; University of Louisville, School of Medicine, Louisville, Ky., 1894; aged 64; former member of the Ohio State Medical Association, and the American Medical Association; died April 9, after a year's illness. Dr. Marquart had practiced in Yellow Springs, Greenville, Osborn and Springfield for 40 years. He was prominent in the Masonic Lodge. He is survived by his widow, a son, Dr. J. Roger Marquart, Springfield, a daughter, two sisters and one brother.

James Wilson Miller, M.D., Cincinnati; Medical College of Ohio, Cincinnati, 1899; aged 64; member of the Ohio State Medical Association and Fellow of the American Medical Association; died April 28. Dr. Miller was attending dermatologist at General, Good Samaritan, and Children's hospitals, and at the General Protestant Orphan Asylum and Institute of Dermatology, University of Cincinnati. He was formerly United States Pension Examiner and formerly attending dermatologist at the United States Veterans Bureau. He was a member of Sons of the Revolution and the Rotary Club. Surviving are his widow and two sons.

W. Arthur Minton, M.D., Bradford; Louisville Medical College, Louisville, 1894; aged 65; former member of the Ohio State Medical Association and the American Medical Association. Dr. Minton was a Mason and a member of the

Presbyterian Church at Bradford. Surviving him are two brothers and a sister.

Francis Marian Murray, M.D., Delaware; Jefferson Medical College of Philadelphia, Pa., 1877; died April 25th, following an illness of six weeks. Dr. Murray practiced in Delaware for many years. He is survived by two daughters and a son.

Ernest Milton Parrett, M.D., Columbus; Starling Medical College, 1899; aged 60; former member of the Ohio State Medical Association and the American Medical Association; died April 15, after a long illness. Dr. Parrett practiced in Columbus since his graduation, and was a member of the staff at Grant Hospital. He was a member of the Broad Street Presbyterian Church, Athletic Club, Crichton Club, Kiwanis Club and the Players Club. Surviving are his widow and three sisters.

Calvin T. Riley, M.D., Woodsfield; Pulte Medical College, Cincinnati, 1881; aged 83. Dr. Riley practiced many years in Monroe and Washington counties. He is survived by a daughter.

William Henry Robbins, M.D., Martins Ferry; Jefferson Medical College of Philadelphia, Pa., 1916; aged 53; member of the Ohio State Medical Association and Fellow of the American Medical Association; died April 18, of an infection. Dr. Robbins began practice at Vanderbilt, Pa., moving to Martins Ferry in 1925. He was a member of the staff of the Martins Ferry Hospital, the First Methodist Church and the Masonic Lodge. Surviving are his widow, three sons, one daughter, five sisters and one brother.

Hubert de L. Spence, M.D., Painesville; Cleveland College of Physicians and Surgeons, Cleveland, 1897; aged 77; Dr. Spence was born in Liverpool, England. He practiced at Kent and Cleveland before moving to Painesville. From 1894 to 1905 he lectured on neurology at Lakeside Hospital, Cleveland. He was a member of the First Unitarian Church of Cleveland. Surviving him are his widow, two sons and a daughter.

James H. Thompson, M.D., Ashtabula; University of Toronto, Faculty of Medicine, Toronto Ont., Canada, 1927; aged 33; member of the Ohio State Medical Association and Fellow of the American Medical Association; died April 6, from pneumonia. Dr. Thompson practiced at Youngstown before going to Ashtabula. He is survived by his widow, a daughter, his parents, a brother and two sisters.

Walter S. Weiss, M.D., Jefferson; Western Reserve University School of Medicine, 1888; aged 71; former member of the Ohio State Medical Association and former Fellow of the American Medical Association; died April 22, following a long illness. Dr. Weiss practiced at Cortland and Rock Creek until 1918, when he moved to Jefferson. Since August 1, 1922, he had been health commissioner of Ashtabula County. He was a member of the Congregational Church, Masonic Lodge, Rotary Club, and the Ashtabula County Board of Education. Surviving are a son, three daughters and two sisters.

Clifford R. Weis, M.D., Dayton; Ohio State University College of Medicine, 1921; aged 40; member of the Ohio State Medical Association and Fellow of the American Medical Association; Fellow of the American College of Physicians; member of the Radiological Society of North America; died April 2, after an extended illness. He served his internship at St. Elizabeth hospital, Dayton, and continued post-graduate work at Harvard and at the Trudeau Sanatorium, Saranac Lake, New York. In recent years he contributed numerous articles to medical publications. Dr. Weis was a member of the staffs of St. Elizabeth and Good Samaritan hospitals. He is survived by his widow, two sons, two daughters, his parents and two brothers.

George W. Wood, M.D., Wilmington; Cleveland University of Medicine and Surgery, 1886; aged 79; died April 1 of pneumonia. Dr. Wood had practiced in Wilmington since graduation. He was a member of the Wilmington Lodge of Masons, and on March 19 was presented with a Grand Lodge service medal, commemorating his 57 years as a Mason. Surviving him are his widow, one son, Dr. Wilford Wood, of Detroit, and one daughter.

KNOWN IN OHIO

George H. Bigelow, M.D., Boston, Massachusetts; Harvard University Medical School, Boston, 1916; aged 45; Fellow of the American Medical Association. Dr. Bigelow, a former member of the Greene County Medical Society, was formerly director of industrial health at Antioch College, Yellow Springs. After leaving Antioch he became health commissioner in Massachusetts.

James Hultgen, M.D., Chicago; Northwestern University Medical School, Chicago, 1900; aged 63; Fellow of the American Medical Association; died March 13. Dr. Hultgen attended Western Reserve Medical School, and took post graduate work in Paris and Strasbourg. He was a veteran of the Spanish-American war. He is survived by his widow, two sons and one daughter; one brother and one sister.

Otis Mallow, M.D., Hines, Illinois; Medical College of Ohio, Cincinnati, 1901; aged 60; died March 10. He was chief diagnostician at the Edward Hines, Jr., Memorial Hospital, Chicago. He formerly resided at Washington C. H. One sister survives him.

Wilbert Shallenberger, M.D., Chicago; Barnes Medical College, St. Louis, 1901; aged 61; died

March 17. Dr. Shallenberger was a native of Lancaster, Ohio. His widow survives him.

David M. Roberts, M.D., Honolulu, H. I.; Medical College of Ohio, Cincinnati, 1895; aged 62; died March 7 following a long illness. Dr. Roberts enlisted as a medical officer during the Spanish American war. He later returned to private practice at New Richmond. At the outbreak of the World War, he returned to army service, and remained in the medical corps. He died two days before he was to have been retired from active army service. Besides his widow, he is survived by one daughter; one brother and a sister.

Burch C. West, M.D., Wellsburg, New York; Jefferson Medical College, Philadelphia, 1906; aged 56; former member of the Ohio State Medical Association, and the Montgomery County Medical Society. Dr. West served his internship at Miami Valley Hospital, and practiced in Dayton until his retirement in 1928 because of ill health. He is survived by his widow and two sons.

PUBLIC HEALTH NOTES

—At a recent meeting in the Chamber of Commerce, Toledo, Dr. Bruce Brockway, school physician, declared that there is less malnutrition among children in the Toledo public schools and child health conditions are better than at any other time since the school system began.

—Dr. Finley D. Van Orsdall, State Department of Health, calls the Ohio rabies situation "a highly alarming condition". His records show that the department found 416 "positive" cases in Ohio from Jan. 1, 1934 to March 4, 1935, of which Scioto County alone had 105. Ten Southern Ohio counties had 49 per cent of the total cases in the state.

—The Defiance County Medical Society and the County Board of Health, cooperated with the Defiance County Public Health League, in a county-wide effort to have as many persons as possible immunized against diphtheria and smallpox.

—Directors of the Zanesville Chamber of Commerce recently went on record as favoring the construction of a tuberculosis sanitorium in Muskingum County.

—I. C. Plummer, chief of the division of vital statistics, State Department of Health, addressed the district advisory council of the Lorain County General Health District at Oberlin recently.

—The City of Maple Heights, near Cleveland, recently withdrew from the County Board of Health, and appointed Dr. Jack Jaffe, as city health commissioner.

NEWS NOTES *of* OHIO

Columbus—Dr. D. V. Burkett has been reappointed chief surgeon and head of the Medical Department of the Ohio National Guard. Dr. Burkett is chairman of the medical board which considers all claims for compensation for injuries and sickness of officers and enlisted men of the Ohio National Guard.

Toledo—Dr. R. C. King, chief of the obstetric and gynecology departments of St. Vincent's Hospital, was elected a councilor in the American College of Surgeons at the annual convention of the college held in Cleveland recently.

Alliance—Dr. G. L. King, Sr., has just completed his fortieth year in the practice of medicine in Alliance. In addition to his professional activities, Dr. King has been prominent in the civic, educational and religious life of the city.

Toledo—Radio addresses under the auspices of the Toledo Academy of Medicine were recently given by Dr. E. B. Gillette on "The Value of Good Health", and by Dr. A. A. Applebaum on "Timely advice for Hay Fever and Asthma Sufferers." Dr. Berman S. Dunham addressed the Evansdale School Parent-Teacher Association on "The Prevention of Contagious Diseases in Children".

Cleveland—Dr. Milton Thomas Ebner, native of Sandusky, who has just completed special training in dermatology in the New York Skin and Cancer Hospital unit of Columbia University, has opened an office in the Medical Arts Building.

Ashtabula—Dr. R. S. Grimmett of St. Louis, Mo., has taken over the practice of D. W. F. Gessler, who recently moved to Ft. Wayne, Ind.

Lucasville—Dr. J. R. Hilling has returned to engage in general practice after residing in Middletown and Mt. Orab.

Columbus—Dr. J. A. Reibel has resumed practice following a three-month convalescence from injuries suffered in an auto accident.

Delphos—Dr. John B. Egts recently celebrated his eighty-fourth birthday. He is still active in the practice of medicine.

New Philadelphia—Dr. W. R. Stager, Dover, and Dr. Henry B. Kistler, Newcomerstown, escaped injury when cars driven by the two physicians collided recently.

Sulphur Springs—Dr. G. H. Carpenter has moved to Bloomville, leaving this village without a physician.

Columbus—Dr. W. B. Morrison addressed the Rotary Club on the treatment of cancer.

Chillicothe—Dr. Wilson K. Dyer of the U. S.

Veterans Staff led a discussion on "Objective Psychotherapy" at the recent annual meeting of the American Psychiatric Association held in Washington, D. C.

Columbus—Dr. Leslie L. Bigelow was elected President of the Kit-Kat Club.

Cleveland—Dr. Arthur C. Poe has completed his fiftieth year in the practice of medicine.

Lorain—Dr. John W. Adrian addressed the South Lorain Business Men's Association on "What's Behind Your Face".

Columbus—Dr. Russell G. Means is convalescing from an appendicitis operation.

New Lexington—Dr. J. G. McDougal was recently honored at a dinner of the Central Ohio Alumni of Beta Theta Pi Fraternity, having been a member of the fraternity for 50 years.

Columbus—Dr. Helen Halsey addressed the Women's Medical Club on "Music as a Therapeutic Agent".

Cleveland—The faculty of the School of Medicine of Western Reserve University recently unveiled a painting of the late Dr. John Elton Darby, who was a member of the faculty from 1861 to 1917.

McConnellsville—Dr. Edgar Northrup, who graduated from the College of Medicine, Ohio State University in 1933, and is now in the United States Public Health Service and located at the Marine Hospital, Staten Island, New York, will return to McConnellsville in June to become associated with his father, Dr. C. E. Northrup, in the general practice of medicine.

Massillon—Dr. R. J. Pumphrey was honored at a dinner in celebration of his completion of 50 years in the practice of medicine. Dr. George W. Crile of Cleveland was the principal speaker.

Washington C. H.—Dr. N. M. Reiff, graduate of Ohio Wesleyan University and the School of Medicine of Western Reserve University, and for the past four years on the staff at St. Luke's Hospital, Cleveland, has become associated with Dr. A. S. Stemler.

Kenton—Among the honored guests at the Frankfort High School Golden Jubilee was Dr. R. C. McNeil, only surviving member of the class of 1887, the first graduating class of the school.

Xenia—Dr. T. F. Myler is the new president of the Rotary Club.

Ashtabula—Dr. Oscar B. Griggs, graduate of Hahnemann Medical College, Philadelphia, has taken over the practice of the late Dr. Albert C. Shute.

Columbus—Dr. Albert D. Frost recently lectured at the fifth annual graduate course in ophthalmology and otolaryngology sponsored by the University of Michigan and the Michigan State Medical Association. His subjects were "Papilloedema and Its Differential Diagnosis", and "Indications for Various Squint Operations".

Columbus—Dr. James J. Hamill, who has been in Vienna, Austria, taking post-graduate work in internal medicine and diagnosis, will return to active practice in July.

Columbus—A two-reel film dealing with technical phases of obstetrics, prepared under the direction of Dr. J. B. DeLee of Lying-In Hospital, Chicago, was recently shown to Columbus physicians and nurses at a local theater.

Findlay—Dr. John V. Hartman, local physician, addressed the student body at Findlay College recently.

Ironton—Dr. Thomas H. Remy, veteran physician, is recuperating from a recent operation.

Cincinnati—Dr. Carl A. Wilzbach and Dr. C. R. Deeds were recently elected to the medical staff of Catherine Booth Hospital, Cincinnati.

Eaton—The 134th semi-annual meeting of the Union District Medical Association was held here April 25. Among the speakers were Dr. Ralph W. Good, Cincinnati; Dr. George M. Curtis, College of Medicine, Ohio State University, and Dr. Thomas B. Rice, Indiana University School of Medicine. Officers of the association are: Dr. Mark Millikin, Hamilton, president; Dr. G. W. Flory, Eaton, vice president, and Dr. W. A. Thompson, Liberty, Indiana, secretary-treasurer. The next semi-annual meeting will be held at Richmond, Indiana, Thursday, October 24.

Gallipolis—Dr. I. L. George, for the past three years a member of the staff of the Ohio Hospital for Epileptics, Gallipolis, Ohio, has gone to Baton Rouge, La., to take up duties in an emergency hospital of the Standard Oil Company.

Bellefontaine—Dr. C. L. Barrett, Bellefontaine, has been appointed physician at the Logan County Children's Home.

Youngstown—Dr. Morris H. Belinky, graduate of the School of Medicine of Ohio State University, has opened an office at 2004 Elm St., this city.

Fostoria—Dr. John J. Blue recently addressed the Fostoria Exchange Club on the subject of "Cures".

Fredericktown—Dr. William Mahaffey, formerly located at Rushville, has opened an office at Fredericktown.

Cleveland—Fourth in a series of lectures under auspices of the American Association of Medical Society Workers was given by Dr. Abraham Strauss, associate chief surgeon of Mt. Sinai Hospital.

Newcomerstown—Dr. Roy D. Hildebrand is taking post graduate work in surgery at New York Polyclinic.

Martins Ferry—Dr. Bertha Metzger Joseph spoke before the Ladies' Auxiliary of Edgewood Park M. E. church recently.

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HOSPITAL NOTES

—Hospitals of the state held open house Sunday, May 12, observing National Hospital Day. The day is the anniversary of the birth of Florence Nightingale.

—Dr. J. D. Schonwald has been appointed medical director at Miami University Hospital, Oxford, succeeding Dr. Wade McMillan, who retired in January. Dr. Schonwald has been assistant to Dr. McMillan for several years.

—The City Council of Columbus has appropriated $20,000 to provide for hospitalization of indigent sick. The fund will be available immediately, and will be administered by City Health Commissioner N. C. Dysart. The ordinance allows three dollars daily per patient.

—Dedication of the Chillicothe City Hospital was held April 14th, the 25th anniversary of the opening of the original City Hospital.

—A contract has been awarded for a $10,000 addition to the Mansfield General Hospital.

—The board of county commissioners has voted to issue $10,832 in bonds to purchase materials for a project to construct an addition to the Robinson Memorial Hospital, Ravenna. Estimated cost of the new construction is $37,796.34. Of this amount the county will provide $10,832 for materials while the federal government is expected to furnish the remainder.

—Dr. Roy E. Schell, assistant physician and surgeon at the Ohio Soldiers' and Sailors' Home hospital, Sandusky, has resigned to become associated with Dr. E. M. Hooper in the Dayton State Hospital.

—The following officers were elected at the annual meeting of the staff of Union Hospital, New Philadelphia, Ohio: Dr. Max Shawaker, Dover, president; Dr. E. D. Moore, New Philadelphia, vice-president, and Dr. C. M. Dougherty, secretary.

—Dr. C. H. Mundy has been elected chief of staff of the Lucas County Hospital. Other officers of the staff are: Dr. F. W. Clements, who succeeds the late Dr. E. I. McKesson as vice-president; Dr. F. B. McNierney, secretary; and Drs. B. S. Dunham, E. C. Mohr, H. B. Meader, L. R. Carr, H. Holmes and E. J. McCormick, executive committee.

—The Marion City Hospital is to receive an oxygen tent through the generosity of the Woman's Board.

—Extensive improvements being contemplated for Martins Ferry Hospital laboratory and X-ray department will so enlarge the branch that a new

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MEDICINE—Informal Course—Intensive Personal Courses, June, July, and August.

SURGERY—General Course One, Two, Three and Six Months; Surgical Technique, Two Weeks Intensive Course—Special Courses.

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OBSTETRICS—Informal Course—Two Weeks Intensive Course—Special Course June 3rd.

FRACTURES AND TRAUMATIC SURGERY—Informal Course——Intensive Ten Day Course starting June 3rd and October 14th.

PEDIATRICS—Informal Course—Personal Courses.

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doctor will be added to the staff in the near future.

—Bequests totalling $2,819.08 were received by the Champaign County Hospital and Childrens' Home from the estate of Miss Ora Wiant.

—Mrs. Margaret Allaman, state welfare director, recently announced plans for a $150,000 expansion program for the Lima State Hospital.

—Bids are being received by the state to provide additions to the tuberculosis hospitals at Dayton and Cleveland. It is estimated that the work will cost approximately $240,000.

—OSMJ—

Corporation Ousted From Practice of Medicine In Decision By Chicago Superior Court Judge

Corporations organized to engage in the practice of medicine through the agency of physicians employed by it received another severe set-back on March 22, when Judge Michael L. McKinley of the Superior Court of Cook County, Illinois, rendered a decision in the quo warranto proceedings brought by Attorney General Kerner of Illinois against the United Medical Service, Inc., of Chicago.

Judge McKinley entered a judgment "ousting the respondent (corporation) from the franchise, occupation and business of holding itself out to the public as being engaged in the diagnosis and treatment of ailments of human beings and from suggesting, recommending, or prescribing any form of treatment for the palliation, relief, or cure of physical or mental ailments of persons, with the intention of receiving therefor, either directly or indirectly, any fee, or compensation, and from diagnosticating, or attempting to diagnosticate, operate upon, profess to heal, prescribe for, or otherwise treat, any ailment, or supposed ailment, of another, and from maintaining an office for the examination or treatment of persons afflicted or alleged or supposed to be afflicted, by any ailment; and from usurping, intruding itself into or unlawfully holding or executing any such franchise, occupation, or business, either by or through the services of physicans and surgeons duly licensed and registered under the Medical Practice Act, and employed and paid by the respondent, or otherwise".

Judge McKinley's decision brings to a climax a bitter fight between the United Medical Service, Inc., and the medical profession of Illinois and represents an important victory for the latter on the question of law as to the right of a corporation to engage in the practice of medicine.

The corporation has signified its intention to appeal to the Illinois Supreme Court. Pending the determination of the cases in that court, because of a writ of supersedeas, the judgment of ouster will stand suspended.

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Laryngoscope, 1935, XLV, 149-154★

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Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245★

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Physicians Paid $22,716 For Care of Injured FERA Workers From April 1, 1934, to January 1, 1935

A report of the Safety and Injury Division of the Ohio Emergency Relief Administration for the period April 1, 1934, to January 1, 1935, was completed recently by D. F. McMurchy, until recently supervisor of that division, who has resigned to become safety supervisor of the big Federal project now under way in the Tennessee Valley.

The function of this division is to carry on safety work and supervise medical services in connection with the thousands of work relief projects being carried on in Ohio by Federal-state funds.

The report submitted by Mr. McMurchy showed the following:

Total number injured—8,926.
First aid cases—5,545.
Medical cases—3,381.
Fatalities—10.
Lost time injuries—468.
Lost time frequency rate—14.2.
Permanent partial disabilities—10.
Temporary, over 7-days disability—318.
Disability, 7 days or under—234.
Total days lost—81,038.
Severity rate—2.458.
Man hours exposure—32,968,086.

The report stated that the cumulative frequency rate of 14.2 represented a reduction of 67 per cent under the CWA experience in Ohio and that the severity rate of 2.458 days lost per thousand hours worked represented a reduction of 45 per cent under the normal experience in the construction industry.

Of the total number of accidents reported, 62.1 per cent were first-aid cases; 37.9 per cent were medical cases; 5.2 per cent were lost-time accidents, and 67.9 per cent of the lost-time accidents were accidents having over 7 days disability.

The infection rate of 3.2 per cent represented a reduction of approximately 75 per cent under the normal experience of the construction industry in Ohio.

A total of $22,716.95 was paid out by the division for medical costs during that period, distributed as follows: Physicians, $18,339.71; hospitals, $4,087.78; miscellaneous, $289.46; X-rays, $1,559.05.

Medical bills were paid in 3,479 cases at an average cost per injury of $6.53.

—OSMJ—

The thirty-sixth annual meeting of the American Proctologic Society will be held at Atlantic City, Monday and Tuesday, June 10 and 11, with headquarters at the Marlborough-Blenheim Hotel.

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To quote these authors—"the differences in fat retention on these various fats as shown on normal infants are not great; for the normal infant it is probably immaterial whether he absorbs 85% or 95% of his fat intake. It seemed possible, however, that *in subjects who have difficulty in fat assimilation, such as premature infants, the observed small differences might become large differences. A few observations made on premature infants and twins have borne this out*—."

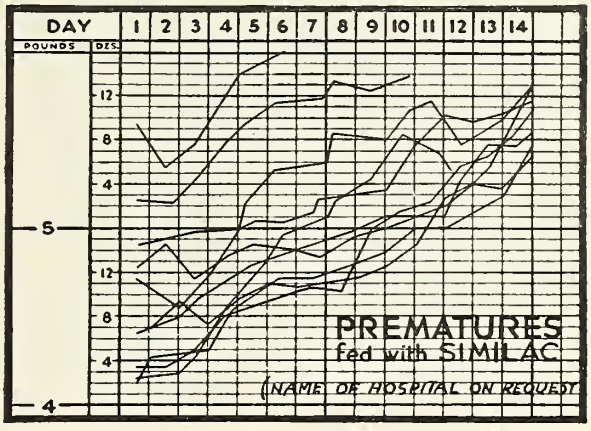
The observations referred to covered only three prematures fed on different fats, but showed an average of 78.4% retention for olive oil as compared to only 52.5% retention for butter fat.

*Holt, Tidwell and Kirk, Studies on Fat Metabolism in Infants—Acta Pediatrica. Vol. XVI, 1933.

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Standard Regulations to Govern Swimming Pools Are Needed

Among relief projects that have been completed during the last year are a number of artificial public swimming pools. They are of various types, ranging from crude structures to modern, up-to-the-minute pools, fully equipped to supply and maintain the safe water that is so essential to their proper operation.

It is unfortunate that there is no law in Ohio governing the construction, maintenance and operation of artificial swimming pools. Several other states have adequate laws for this purpose and, soon or late, Ohio will fall into line and make proper provision to take care of this rapidly growing public utility.

A pool that is well constructed, properly equipped with suitable apparatus to treat the water to make it safe for bathing, and which, when properly operated, is an institution that will provide healthful recreation and can be made to pay its own way in a community, is an asset to the locality it serves; but a poorly constructed pool, or one that is properly developed but is unsatisfactorily operated, may very easily prove to be a menace. It is therefore essential that health officials take note of projects of this type, when proposed for their communities, and endeavor to have proper plans prepared for their development and management.

Although the State Department of Health has not been authorized to supervise the planning, construction or operation of artificial swimming pools, it realizes the importance of proper design and operation, has prepared a set of regulations covering minimum requirements for a safe pool, and suggests that local boards of health, which have full power to act, adopt them, or similar regulations, so that thereafter it will be possible not only to control the development of such projects but also to require proper operation, and thus safeguard the health of patrons. It will be only a few months until every swimming pool in the state will be in full operation; wherefore, the earlier action is taken in this matter, the better conditions will be for all concerned.

It also is worthy of official consideration that there is no time like the present for communities which can utilize these installations on a paying basis to put their plans under way, as they fall in a category making them eligible for Federal aid as a works relief measure. It will be essential first to adopt the suggested regulations, so that the installations may be planned, built and operated according to a definite acceptable standard.—*Ohio Health News.*

—OSMJ—

—Dr. C. K. Startzman, Bellefontaine, has been retained as physician for the Logan County Home.



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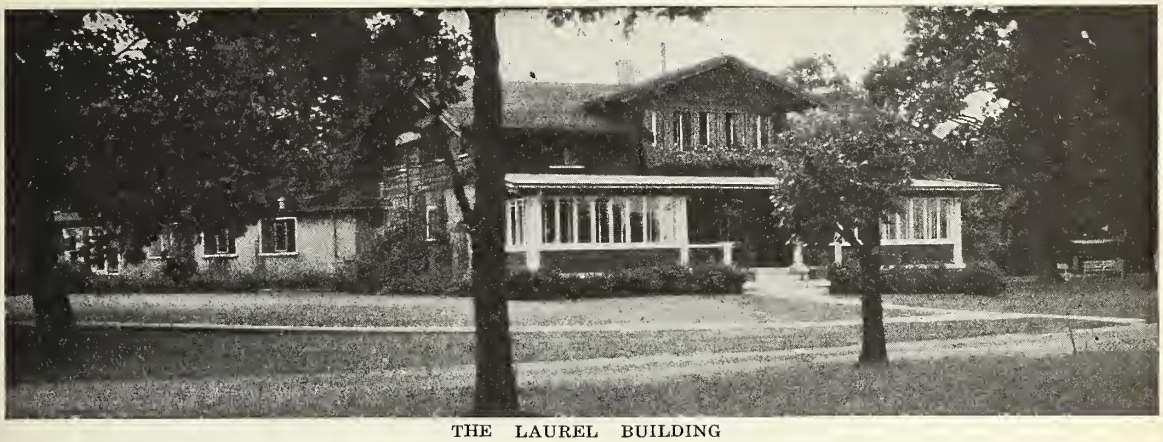
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Vol. XXXI JULY, 1935 No. 7

CISTERN (SUBOCCIPITAL) PUNCTURE*

By DANIEL J. KINDEL, M.D., CINCINNATI, OHIO

CISTERN or suboccipital puncture is a method possessing certain advantages by which the cisterna magna may be entered for diagnostic and therapeutic purposes. It is a safe and simple method, ideally adapted to routine clinic or office use.

According to Spiegel[1] who has exhaustively reviewed the literature up to 1928; Wegeforth, Ayer, and Essick[2] first described the method in this country in 1919, and Eskuchen[3] working independently, published his work in 1923. Although extensively used abroad, mainly in Germany, it has only been in the past five years that this method has gained routine use in this country and an adequate experience has been accumulated.

It was my privilege, under the guidance of Spiegel and Saunders,** to study this procedure, observe the uniformly satisfactory results, and perform a number of cistern punctures. Subsequently the procedure was introduced as a routine in the syphilis department at the Shoemaker clinic in Cincinnati, and the neuro-syphilis clinic at the Cincinnati General Hospital. To date I have personally performed over four hundred punctures and observed a similar number.†

ANATOMY OF THE SUBOCCIPITAL REGION

The cisterna magna or cerebello medularis, one of the four great cisterns of the subarachnoid space of the brain is a triangular or funnel shaped area, the anterior wall being formed by the dorsal surface of the medulla and upper cervical cord. It is continuous with the subarachnoid space of the cord, through the foramen magnum and may be said to extend to the level of the first cervical vertebra or atlas. The posterior wall is formed by the reflection of the arachnoid from the cerebellum to the medulla, forming a space about 1. to 1.5 cm. in depth. The occipito-atlantoid ligament stretches from the posterior rim of the atlas to the corresponding rim of the foramen magnum, forming the occipito-atlanoid ligament. This ligament is practically fused with the dura and the cistern lies immediately beneath it. It is the last point of resistance felt before the needle point enters the cistern.

The distance of the cistern from the skin varies from 2.5 to 7. cm., usually being from 3 to 5 cm.

The important external land marks are the spine of the axis and the occipital protuberance. The atlas cannot be palpated.[4]

From without inward, the structures in the midline traversed by the needle are: skin and subcutaneous tissue, nuchal ligament, fused origins of the neck muscles, occipito-atlantoid ligament, dura and arachnoid.

With the exception of the spinal veins of the pia, and the anastomoses connecting the external and internal vertebral plexuses, there are no blood vessels of any importance in the midline.

Read before the Medical Section, Ohio State Medical Association, at the 88th Annual Meeting, Columbus, October 4-6, 1934. Illustrated with motion pictures.

*From the Department of Dermatology and Syphilology, University of Cincinnati Medical School and General Hospital.

**Department of Dermatology and Syphilology, New York University and Bellevue Hospital service of Dr. Howard Fox, and Lennox Hill Hospital Neuro-syphilis Clinic of Dr. Leo Spiegel, through whose kindness I was permitted this opportunity.

† Since this paper was written more than 250 additional punctures have been done.

However, it is essential to bear in mind that the vertebral artery ascends through the transverse processes of the cervical vertebra on either side. An inferior cerebellar branch from the circle of Willis traverses the inferior surface of the cerebellar lobes.

THE INDICATIONS FOR CISTERN PUNCTURE

In modern diagnosis and therapy the withdrawal of cerebrospinal fluid and the introduction of therapeutic agents into the subarachnoid space is assuming more and more importance. At the moment the diagnostic possibilities greatly exceed those of therapy, and it is essentially in connection with the former that we are concerned.

The diagnostic phase is probably most widely used in the management of syphilis, and it should be emphasized that a spinal fluid examination during the earlier stages of syphilis will in many instances disclose cases disposed toward the development of central nervous system involvement and thus prevent the development of unfortunate sequelae of advanced cases beyond repair. It is of further value in determining the nature of the pathology present, as well as the prognosis and effectiveness of therapy.

A few of the conditions in which diagnostic puncture is also indicated are cases in which meningitis, poliomyelitis, or encephalitis are suspected; intracranial hemorrhage, spinal block, coma, convulsions, paralysis and encephalography.

Since this is not the place to discuss therapeutic indications, they will be mentioned only in passing. Such are: simple and forced drainage, the introduction of serums and drugs in meningitis, tetanus, eclampsia, uremic coma, convulsions, persistent headaches of certain types (migraine), and others.

ADVANTAGES OVER LUMBAR PUNCTURE

1. From 30 to 60 cc. of fluid can be obtained by cistern puncture and it is routine to withdraw from 17 to 25 cc. Lumbar puncture yields an average of 15 cc.

2. Bloody taps are very infrequent with perfected technique, rarely occurring if properly performed. Occasionally the stylet is removed before the cistern is entered and blood will appear. If the midline plane has been carefully followed, such bleeding occurs from a branch of the posterior occipital blood vessels and is entirely extradural. One may continue to advance the needle.

3. Severe headaches have not been observed, in fact slight headaches occur only infrequently. When they do occur their duration is but a few hours and they are easily controlled. In some cases, headaches, present before puncture, were not aggravated. In other instances, particularly associated with increased pressure, relief was experienced following cistern puncture.

4. Patients are instructed to sit up immediately following the tap, and after resting for five minutes, are dismissed. The patient proceeds with his regular routine without further inconvenience.

5. Since less resistance is encountered in doing cistern puncture, less force is required to enter the cistern and a small bore needle may be used with relatively greater safety and without fear of breaking the needle.

6. While it is well to avoid movement on the part of the patient, sudden jerks will not damage the brain stem, as the point of the needle in situ assumes the attitude of a fulcrum[4, 1]. There is corresponding less likelihood of breakage under these circumstances due to the nature of the structures that are penetrated.

7. No local anesthetic is necessary, nor is one desirable as it may obscure the landmarks.

8. With the assistance of a capable nurse, 8 to 10 punctures can be made within an hour, thus lending the procedure particularly adaptable to a busy clinic. Likewise cistern puncture can be done as an "office" procedure and hospitalization is unnecessary.

9. Aseptic meningitic signs of temporary nature such as reported in three cases of lumbar tap by Reynolds and Wilson[5] presenting findings of fever, stiff neck, Kernig's sign, stupor and delirium, have not been noted.

10. In spinal block whether due to trauma or a disease process (fibrinous exudation) fluid is obtained from cistern puncture in instances where lumbar tap fails.

11. It has been shown by Goldman[6], Dandy[7] and others, that the diffusion and distribution of the substances injected into the cistern are much more effective than when introduced into the lumbar region. India ink injections scarcely reached the base of the brain whereas when injected into the cistern the entire base was heavily stained. This is important in the therapy of meningitis and tetanus.

12. In animals and at the autopsy table cistern puncture offers a simpler method for obtaining fluid than spinal tap. It is almost impossible in some animals, depending on the structure of the vertebral column, to do a lumbar puncture.

13. It is an easier procedure on the patient and for the operator. Ayer states: "It was noticeable that the apprehension attending earlier punctures was entirely with the operator and was not shared with the patient, whose ignorance of the proximity of the medulla served him to advantage."

SAFETY OF CISTERN PUNCTURE

Cistern puncture while not fool proof is a safe procedure. This must be qualified by the statement that detailed care must be exercised at all times. In one series of 10,000 cases Eskuchen reported seven deaths. Two other series of 1,500 to 3,000 taps reported one fatality each. Two deaths[8] were reported two years ago by Russum and Barry[6], both of these were in infants with menin-

gitis. Gilman and Kempf[4] in 5,000 punctures report one case which at the autopsy table showed hemorrhage from the dura about the base of the brain possibly due to puncture. The cause of the death was purulent meningitis with multiple abscesses in the brain. Vonderahe and Haberman[10] report a case of purulent meningitis in which death followed four hours after cistern puncture. Injury to the medulla and hemorrhage was demonstrated. Speigel has done over 5,000[9] and Saunders a similar number with no fatalities. It is only fair to assume that others have occurred and have not been reported, but it must be remembered that most of them occurred while the procedure was being developed, and more recent results make the consideration of the very occasional accident rather negligible in view of the information obtained and the advantages gained.

CONTRA-INDICATIONS

The major contra-indication to cistern puncture is the performance of this procedure without proper preparation of the operator. It is not devoid of significant potential dangers and if unfortunate sequelae are to be avoided the operator must have studied the procedure adequately. The anatomy of the region should be reviewed preferably by study of actual anatomical sections. It should be done on fresh cadavers and a number should be observed before an attempt is made in living subjects. Even then it is well to perform the first ones under the guidance of a competent operator.

Unless there is an imperative reason for it, cistern puncture should not be done in the presence of acute exanthemata, septicemia, or untreated active syphilis, because of the possibility of introducing meningeal involvement.

The normal anatomical dangers have been discussed. Anomalies of the vertebral artery, aneurism of the circle of Willis cannot be foreseen as a rule. This may be true of cerebral neoplasms. While such are of infrequent occurrence, they have accounted for some of the deaths cited above.

What Reynolds and Wilson[5] say with regard to lumbar tap also applies to cistern puncture.

"The danger of lumbar puncture in a patient suspected of harboring a cerebral neoplasm has been greatly overestimated, particularly in that group lacking roentgen evidence of increased pressure and presenting normal eyegrounds. In the ordinary case of brain tumor with headache, choked disk, and other symptoms there is no occasion to do a spinal tap. Sudden death, respiratory failure, stupor and convulsions have been known to occur after spinal tap in a patient with a brain tumor, especially if it is located in the posterior fossa, but the same things may happen when no puncture has been done. Nevertheless, a tap should not be done in a patient with a posterior fossa neoplasm or in a cerebral abscess when a real danger exists, in that a meningitis may be produced and even rupture of an incompletely walled off abscess occur."

Care should be exercised in puncturing individuals over 55 years of age, or arteriosclerotics. It should not be done in the presence of a local inflammatory process and difficulty may be experienced due to deformities or abnormaly thick neck structures. The latter two, are elective contraindications.

TECHNIQUE

No special equipment is required excepting proper needles and a small head block or hard pillow, high enough to keep the head and cervical vertebra in horizontal alignment. Of course aseptic precautions should be followed, and a sterile tray set up is required. I use a 19 guage, 6 cm., Spiegel needle with a round metal disc at the proximal end of the needle proper. The shank or base of the needle is reinforced for stability. This disc is sometimes spoken of as a guard, or thought to be the depth to which the needle should penetrate. Neither is correct; it is intended primarily as a rest for the first and second fingers. With the thumb on the stylet a three point suspension is obtained, giving the operator absolute control of the direction and leverage. After the skin is penetrated the index finger of the left hand is also placed on the disc, providing additional stability. The disc does serve as a guage to show the operator how far the needle has penetrated. The distance to the cistern may be roughly estimated by determining the measurement between the posterior border of the mastoid process and the suboccipital triangle.

The patient is instructed to lie on his right side with knees flexed, arms folded across chest, right ear resting on the head block, and the chin moderately flexed on the chest. The erect or sitting position is not used because of a negative pressure in the cistern. A simple demonstration is an infant whose fontanelles are open. In a lying posture they bulge; erect they are scaphoid. The shoulders and head must be in vertical and horizontal alignment. A nurse supports the head in this position. The hair is shaved or clipped and skin asepsis is carried out. A sterile drape is placed over the shoulders, and in women the hair is tied up with a loop of bandage. It is essential that the operator bend over and place himself as nearly parallel to the patient as possible in order to observe the proper perspective of the planes.

The index finger of the left hand palpates downward from the occiput toward the spine of the axis. The deepest depression between these points is found. If necessary this is repeated several times where the landmarks are indistinct. With the finger resting snugly in this depression and pressing firmly on the spine of the axis, the needle held in the right hand by the three point suspension (described above) is quickly driven through the skin. Practically no pain is felt after the skin

is penetrated. The needle is then passed upward and forward until the occiput is touched at or near the posterior rim of the foramen magnum, all the time remaining exactly in the midline. The tip of the needle should never be allowed to point below the eyebrows and should be directed toward the hair line. The stylet is removed and the needle point after being very slightly withdrawn is depressed and gradually advanced until the "give" in the dura is felt. It should be emphasized that the "give" is not always felt, even by those who have done a great number of cistern punctures. Fluid will flow freely when the cistern has been entered. Occasionally the drops of fluid will appear very slowly. A slight turn of the needle will often change the position of the point to permit a free flow. A more rapid flow is obtained by instructing the patient to count from one to five repeating this rapidly. A deep breath or compression of jugulars will accomplish the same.

The needle is removed by a quick pull in line with its insertion, pressure being made on the surrounding tissues while withdrawing it. The patient sits up immediately, usually feels light headed or dizzy for a few minutes, and then may go about his routine with no further inconvenience. It is well to have them rest for five or ten minutes.

Two basic methods of inserting the needle are used. Minor variations in technique have been described by other authors. Personally I prefer to re-insert the stylet each time the needle is advanced thus preventing "punching out" of the tissues and contamination of the lumen by blood from the tissues. The indirect or Eskuchen method is the one just described.

The Ayer or direct method begins at a point slightly lower than the indirect. The finger palpates the axis instead of the depression above it. The needle is passed forward and upward in line with the external auditory meatus and glabella and enters the cistern directly without touching the occiput. Entered at this angle there is usually a space between the dura and medulla of 2 to 3 cm. While both methods have proved equally satisfactory, I would advise the use of the indirect until the operator is sufficiently familiar with the feel of this region before using the direct method. In the Ayer method the needle penetrates only soft tissue. The periosteum is not irritated. The anastomoses connecting the external and internal venous vertebral plexus which are a formidable bleeding hazard, are avoided.

If the entire procedure is performed slowly, the stylet removed three or four times before the dura is pierced, and absolute middle planes are followed, little difficulty will be experienced.

If difficulty is encountered, prodding around in an effort to gain entrance is dangerous and it is not to be practiced. If there are any complaints of pain, tingling or numbness except at the point of puncture, the patient should be immediately dismissed and the procedure repeated in two or three days.

In more than 400 punctures we have failed to reach the cistern upon the first attempt in about 6 per cent of our patients. Most of these were elective failures however, for if fluid was not obtained at what was thought to be the proper depth, using gentle aspiration, the procedure was stopped at once and repeated later. It is extremely hazardous to persist in manipulation or prodding with the needle, and this cannot be overemphasized. Failure is due to undue haste, improper preparation, position or shifting of the patient, deviation from the midline, excessive apprehension of the patient or unusual complaints. We have never been unsuccessful on the second attempt and have had no so-called dry taps.

No fatalities have occurred in this group. Two patients complained of numbness and tingling in one hand which lasted only a few minutes. Another complained of sharp pain in the left side of the face, another of pain in the left foot. These were probably due to direct stimulation of the medulla or cervical nerves caused by deviating from the midline. No symptoms persisted more than five minutes and no subsequent discomfort or sensation was noted. One patient with a history of previous attacks of epilepsy left the clinic, returned twenty minutes later with his aura, developed a violent seizure, but recovered promptly with no further difficulty. He had had a previous attack following intravenous medication. Whether this was a coincidence or precipitated by the cistern puncture it is difficult to surmise, however, I am inclined toward the latter.

The rate of flow of the fluid averages 60 to 80 drops per minute, occasionally going as high as 240.

Gross and microscopic contamination with blood is seldom found. There were no subsequent after-effects of any consequence. In fact, patients are given positive assurance to this effect beforehand. Many of them have had previous spinal taps with varying periods of disability up to two weeks. These same patients had no difficulty following cistern puncture.

CONCLUSION

Cistern puncture if carefully done is a safe and simple procedure ideally adapted to routine clinic or office use. Used chiefly for diagnostic purposes in the management of neurosyphilis it possesses definite advantages over spinal tap. The anatomy of the suboccipital region, indications, contraindications, safety and advantages, technique and results are discussed. Positive assurance can be given the patient that there will be no unpleasant after-effects.

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THE POST-OPERATIVE TREATMENT OF CATARACT

By ABRAM B. BRUNER, M.D., CLEVELAND, OHIO

THIS paper aims to present to you, in more or less detail, the usual treatment followed after extraction of the lens in senile cataract, along with a brief discussion concerning the management of certain complications. The same methods of treatment, however, with more or less modifications, would apply after linear extraction, discission or removal of membranous cataract.

The after-treatment of cataract begins the moment the toilette of the wound is completed. Two drops of atropine sulphate solution, 1 per cent, are instilled into the operated eye, followed by unguentum bichlorid 1:3000, and the patient is directed to gently close both eyes and keep them closed. He is at once reassured as to the outcome of the operation, requested to quietly relax and warned against sneezing and coughing, and directed not to talk. It is briefly explained to him that his head will be supported by an assistant while the dressing is applied, and he will then be gently lifted from the operating table into his bed. Some of our operations are performed with the patient in his bed and not on an operating table.

An eye pad and bandage is then applied. The bandage should be applied smoothly without constriction of the scalp or pressure on the lobe of the ear. A small pad of cotton is then placed over the bridge of the nose and the usual black cardboard cataract mask fastened on with its ties and adhesive tape. The unoperated eye is not bandaged and a small hole is cut in the mask before this eye permitting the entrance of some light. We have found no practical objections to treating the unoperated eye in this fashion, as we find by experience that patients rarely open it anyway the first twenty-four hours and then only for a moment at a time. It adds greatly to the comfort and assurance of the patient, and we have never had a case of extreme restlessness or mania since we began to follow this procedure.

When the patient is placed in bed, he is allowed the number of pillows he is ordinarily accustomed to, or the head of the bed is elevated to a semi-prone position. In other words, we attempt to follow this maxim: get the patient into the position most comfortable for him, and it will be easy for him to be quiet.

After the patient is returned to his room, he is visited by the surgeon before the later leaves the hospital. Supervise any slight changes in position, and instruct him that he must remain on his back for eight hours and at no time attempt to raise his head. At the end of eight hours he may be turned on the unoperated side and a pillow placed behind his shoulders. The head of the bed may be raised or lowered at any time as the patient may request.

Two other minor measures will add to the patient's comfort. Have the bed so placed in the room that the operated eye wil be toward the wall, and if the patient's unoperated eye is blind, place side boards on the bed. Explain to the patient that the side boards are put there for him to feel, and to give him assurance that he will not fall out of bed while asleep.

The semi-elevated and lateral positions have to a large extent done away with backache and gastric pains in our patients, and we rarely hear any more of these formerly common complaints.

Liquid diet only is given the first day, but after twenty-four hours the patient is placed on a semi-soft convalescent diet. When the patient is allowed out of bed, he is placed on the regular hospital diet.

Sedatives are given the first and succeeding nights if desired. Pentabarbitol, 1 to 3 grains, is very satisfactory or codeine may be given hypodermically. Morphine is given only in cases of mania.

The patient is permitted to have all the light in the room he desires. The old habit of condemning all eye cases in hospitals to endure days and nights of dungeon gloom, appears to us as entirely irrational therapy.

The operated eye is dressed every day, and during the dressing the room is made semi-dark. At the first dressing the mask is altered with scissors so as to completely uncover the un-

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operated eye. The lashes are wiped off very gently with a pledget of cotton, moistened with boric and saline, and the patient requested to gently open both eyes and look up. Instruct him firmly not to look down. It the patient opens the eyes freely, a hasty inspection can be made the first day. If he will not open the eye, no attempt is made to inspect it the first day, unless there are external signs of infection or the patient complains of severe pain. Everything seeming satisfactory, two drops of 1 per cent atropine are instilled and pad, bandage and mask reapplied.

Subsequent dressings are easier and also more complete. After cleansing the lid margins, adrenalin 1:1000 is instilled to help us determine the amount of injection, if any, that is purely conjunctival in type. The conjunctival sac is then irrigated with a solution of boric and saline, then several drops of zinc sulphate ¼ per cent and one drop of 1 per cent atropine or ½ per cent scopolamine are instilled.

Usually by the second day the eye can be readily and thoroughly inspected, although if there is any blepharospasm or ptosis, we do not attempt to see the wound. By the fourth day it is possible to examine hastily with the ophthalmoscope.

On the seventh day the pad and mask are removed during the day and dark glasses supplied. The pad and mask, however, are reapplied each night as long as the patient remains in the hospital. Also on the seventh day the patient is allowed to sit up in a chair for one hour morning and afternoon, on the following day he can sit up as long as he likes, and the next day he may walk with the aid of a nurse. He is cautioned never to get in or out of bed without the help of a nurse, and never to stoop over or strain. Patients are not allowed to comb their own hair, wash their own face, shave or take tub baths.

Regulation of the bowels is very important. If the bowels have not moved, a simple enema is given the second night following operation. On succeeding days mild laxatives, such as magnesium sulphate, mineral oil or petrolagar can be prescribed or the enema may be repeated if necessary.

Loss of appetite or slight nausea may be overcome with small amounts of ginger ale or champaign. All patients are allowed small amounts of wines or liquors if they have been accustomed to them at home.

Most of our cataract cases are able to leave the hospital the eleventh or twelfth day postoperative. During their entire stay visitors are strictly limited. Only members of the family are permitted, but I have no objection to one member of the family being constantly present, provided they do not annoy or tire the patient. Patients whose unoperated eye is blind, are never left alone for one minute. With all cases, if possible, I prefer a special nurse the first two nights. In fact our hospital regulations require a nurse or maid in constant attendance with every cataract case, private or charitable, the first twenty-four hours after operation.

For the sake of emphasis, I repeat that distant relatives, friends and well-wishers should be rigidly excluded.

The medicinal agents used in the eye in an uncomplicated case are very few. We are accustomed to instill adrenalin 1:1000 at each dressing if there is any conjunctival injection. This satisfies our curiosity as to the character of the injection. As a lotion, we use boric acid and saline in proportion of gr. 40 and gr. 8 to each four ounces of sterile water. Sodium carbonate gr. v to ℥ī may be added to this if desired. For its mild astringent action, zinc ¼ per cent is used, routinely following the irrigation. As a mydriatic we use either atropine 1 per cent or scopolamine ½ per cent, and if a lubricant is desired unguentum bichlorid 1:3000.

If one includes all the aberrations from the ideal in the healing and recovery of cataract cases, then we must concede that complications are much more common than generally admitted. Fortunately, the most common are as a rule the least serious. A few remarks about some of these conditions seems appropriate in a paper of this type, but my discussion is necessarily limited.

Conjunctivitis of varying virulence forms the most common of all complications. Thorough irrigation with boric and saline solution and use of zinc sulphate ¼ per cent will retard its development in many cases, and most of them promptly clear up after removal of the bandage and sutures. If the congestion is more than ordinary, and if a mucopurulent secretion is present, I prefer to use ethylhydrocuprein ¼ per cent and frequently administer milk protein.

Atropine poisoning is certainly very frequent. Puffiness of the upper lid, slight redness and a dry appearance of the skin and moderate itching are the earliest signs to be looked for. Use of scopolamin as a substitute for the atropine and application of zinc ointment U.S.P. to the lids externally will produce a rapid cure.

Striate keratitis usually causes little worry, but I believe it deserves more attention. In my experience it occurs usually in elderly patients with a history of chronic constipation and a tendency to suffer with chronic arthritis of any type and various kinds of peripheral neuritis. In all our cases of striate keratitis, special attention is given to the bowels and moderate doses of salicylates are given daily. Dionin may be prescribed later, but is never used the first two weeks.

Delayed re-formation of the anterior chamber usually occurs in elderly people. It is much less common in younger patients, and then is usually

due to prolapse of iris or vitreous, to hemorrhage under the flap, to jagged section, or to poor apposition of the wound edges. Any prolapse will require the usual treatment for such condition—in the other cases treat the evident cause. In our most elderly patients many cases show no obvious apparent cause. Where possible, remove the bandage during the day and get the patient out of bed the end of the first week. By this time, too, the eye may be anesthetized with cocaine and the wound gently wiped off with a cotton applicator moistened with 1 per cent silver nitrate. Of great importance in these cases is the fact that they nearly all develop a low grade iritis during the second week. This may manifest itself only by the formation of a few small posterior synechiae. The likelihood of such a complication should be borne in mind, and appropriate treatment started at the earliest sign of trouble.

Ptosis of moderate degree seems more common since the widespread use of the O'Brien method of infiltration. Other cases are the usual blepharospasm. It usually worries the relatives more than the patient. Its presence should be admitted, and my experience has been that it is quite safe to promise an eventual cure.

Iritis of very slight degree occurs in every cataract extraction. One should early recognize the cases that constitute a menace to rapid recovery. The amount of ciliary injection may be very slight and subjective symptoms entirely absent. Cortical remnants or dense capsule are definite predisposing factors. Inspect the eye carefully, and at the first signs of iris hyperaemia or pigment proliferation along the pupillary margin, institute treatment. The action of the mydriatic already being used may be augmented by a coup-sur-coup with adrenalin, cocaine and homatropine once a day and injections of foreign protein, preferably milk, are started at once.

Post-operative hallucinosis and mania have never occurred on our service since we ceased to bandage the unoperated eye. If it does occur, however, remove the mask over the unoperated eye at once, and administer morphine in large doses—one-half a grain should be given as the initial dose, and it may be repeated if desired. Paraldehyde has not proved efficient in our past experience.

Secondary glaucoma should be watched for. It rarely appears until after the second week, however.

Prolapse of iris or vitreous if covered by the conjunctival flap, is left alone and treated later. If uncovered, excision is necessary. It is the usual cause of delayed healing, however, and where present will require that the patient be kept quiet in bed for some extra days. Since purely corneal section has been largely abandoned, these complications are much less frequent.

Detachment of the choroid requires no treatment. Detachment of the retina may possibly be cured by the newer operative measures in carefully selected cases.

Small anterior chamber hemorrhages and hyphema occur most often from the third to the sixth day. The bleeding may come either from the conjunctiva or iris, and trauma plays a part in a very high percentage of cases. Generally the blood is absorbed without serious damage to vision, but a few cases are so severe as to cause loss of useful vision.

At the least sign of hemorrhage, we administer fibrogen ½ to 1 cc. and repeat this regularly every second day. If the wound is well sealed, hot packs are applied, but only when the services of a skilled nurse are available. I have had no experience with paracentesis of the anterior chamber.

Cystoid scar is fortunately a rare complication which produces a marked astigmatism. No treatment is known. Expulsive choroidal hemorrhage and septic infection do occur and are perfectly hopeless.

1214 GUARDIAN BUILDING.

DISCUSSION

JOHN E. L. KEYES, M.D., Youngstown: Dr. Bruner is to be commended for bringing before us a phase of ophthalmology with which we all must deal at frequent intervals. It is highly desirable that at medical meetings not only rare conditions should be considered but also those of more frequent occurrence.

After a combined cataract extraction or iridectomy, if the pillars of the coloboma of the iris are not in good position, or if there is any possibility of the iris being caught in the wound, I use a miotic, changing to a mydriatic at the time of the first dressing which is usually 48 hours later. I have not yet been able to bring myself to the practice of leaving the unoperated eye open except possibly when it is blind, and even then I prefer to close it for 24 to 48 hours. I am of the opinion that with both eyes closed, and no incentive to move them, particularly downward, there is a better chance for early and rapid adhesion of the lips of the wound. I also feel that if one has used a suture it is less apt to become loosened when the eye is still.

I have noted post-operative mental aberration more frequently in the deaf, those of limited intelligence, and after the exhibition of barbital compounds. Early recognition of this condition and uncovering the unoperated eye will usually restore the mental equilibrium.

I believe it is very important for the patient to be free from pain and irritation during the 24 hours following his or her operation. Formerly it was my custom to wait until the patient became restless before administering a hypnotic or sedative. Now pantopon is given hypodermically during the first post-operative half hour.

Since replacing morphine and codeine by pantopon there has been very little nausea or vomiting. I do not hesitate to repeat it.

As further aids in procuring a restful immediate post-operative period, two precedures seem of prime importance. I. The avoidance of

possible nausea and vomiting by abstinence from nourishment for several hours after operation. 2. It is highly undesirable that the patient should be exposed to the strain of flatulence, bowel evacuation, or an enema during the first 48 hours. This can be avoided by having the lower bowel well emptied on the day of operation and restricting intake afterward.

I heartily subscribe to Dr. Bruner's practice of making the patient comfortable. Ophthalmology, being the oldest of the medical specialties, suffers from considerable medical folk-lore. An example of this is placing a patient, who has had an intraocular operation, on his or her back without any support for the head, particularly stout, short necked individuals. I believe it is safe to use a thin, medium hard pillow and to elevate the head of the bed slightly.

Another inconsistency is to place a patient with both eyes patched and bandaged and wearing an opaque mask, in a darkened room. It is much safer to have good lighting. It will not affect the patient and it is easier for the nurse or attendant to watch him or her. Reduced illumination, of course, is necessary at time of dressing.

Eye surgeons may be divided into irrigators and non-irrigators. In most instances I belong to the latter class. A fundamental principle in attaining good results in cataract surgery is the avoidance of sudden pressure upon the operated eye. This the patient applies when he or she brings into action the orbicular part of the orbicularis palpebrarum muscle. It is my observation and experience that the fewer procedures employed in dressing this type of eye the less the chance of the patient exhibiting a severe squeeze.

In connection with the foregoing it is essential that a patient with both eyes closed, or one who does not see well, should be addressed before being touched, particularly is this true before administering a hypodermic.

CHARLES LUKENS, M.D., Toledo: This paper certainly gives a most painstaking and orthodox description of the post-operative treatment generally followed in this country. However, the routine and almost limitless use of atropin after cataract operations, sometimes producing "atropin poisoning," is questioned by many. I have personally seen glaucoma produced, requiring complete reversal of medication to eserin; another eye lost from atropin conjunctivitis; and generally much redder eyes than where no atropin had been used. If iritis occurs a few drops of scopolamin solution may clear it up; if not, milk injections have accomplished vastly more than any mydriatic, in cases which have been under my observation.

F. G. STUEBER, M.D., Lima: In this interesting paper, as I understand, the essayist makes it a practice of leaving the unoperated eye open after the second day. After twenty-four hours dresses operated eye, using atropine and bichloride ointment. Personally, I prefer to keep both eyes bandaged three or four days.

Having completed the operation, if exposure of eye has been prolonged instill a dropper full of boric or saline solution; change dressings rarely before the fourth day; at which time several drops of atropine solution are instilled. After forty-eight hours may drop a small quantity of boric or bichloride solution on the dressings.

Cocaine anesthesia has been popular for many years; using 6 or 8 per cent solution frequently "dulls" the corneal epithelium, especially if exposure has been prolonged here a dropper full of boric or saline solution is indicated. Then a thin film of sterile cotton over the closed lids, eye pads, bandage and Ring mask, seldom resort to tying the hands. Far better for the patient's comfort to have night and day care, nursing first three or four days.

THE ROLE OF GLANDULAR THERAPY IN THE TREATMENT OF BEHAVIOR DISORDERS OF CHILDREN

By LOUIS A. LURIE, M.A., M.D., CINCINNATI, OHIO

AN analysis of the first thousand cases of behavior disorders of children studied at the Child Guidance Home showed that endocrine disturbances of various types and grades of severity were present in approximately 20 per cent of the cases. In 9.1 per cent of the cases, the glandular disturbances were the principal causative or determining factors. In other words, in 93 cases of this series there was apparently a direct etiological relationship between the endocrinopathy and the behavior difficulty presented by the child.

This is a startlingly large percentage and fully warrants the statement that no study of a child who presents a behavior difficulty can be considered complete unless it includes a thorough examination of the glands of internal secretion.

From time to time, various writers have called attention to the role of endocrinopathic states in the causation of atypical and abnormal human behavior. In 1921, Scott and Broderick,[1] writing on "The Therapeutic Uses of the Anterior Pituitary Gland", pointed out the necessity for careful endocrinologic study of children showing behavior difficulties. They made the following significant statement: "We see children developing in a hesitating way both in mind and body, not growing straight. We are too apt to think of it as character deficiency, or we call it laziness or

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From the Child Guidance Home, Cincinnati, Ohio.

willful stupidity, but it is nearly always an endocrine deficiency".

In 1927,[2] and again in 1929[3] the essayist pointed out the marked incidence of endocrinopathic states in children who showed abnormal conduct reactions.

In 1931 Rowe,[4] in an analysis of 104 cases of children presenting behavior disorders, found that 68 had an associated endocrine disorder. Of these, those with pituitary disorders constituted the dominant majority, namely, 53. It is his opinion that "endocrine disorders with lowered levels of function frequently are susceptible to correction by endocrine therapy when active preparations are available. Many cases in this series presenting an endocrinopathy with the behavior problem have shown marked improvement in the latter where judicious treatment has palliated the former".

A little thoughtful consideration of the functions of the ductless glands will show why they play such an important role in the psychopathology of behavior disorders of children as well as adults.

The activities of the ductless gland are manifold. It is safe to say that there is not a single bodily function that is not directly or indirectly influenced by them. They are concerned with the differentiation of tissue, with nutrition and growth, and with mental development. In brief, they are intimately bound up with all development, physical as well as mental. Not only is our stature and shape largely determined by the various glandular secretions but also our interlectual capacity and personality make-up.

The mental retardation of the cretin is due to the same lack of thyroid secretion as are the physical changes. This fact has been known for a long time. The fact, however, that disturbances in the functioning of other glands of internal secretions may cause the individual to develop personality traits and characteristics which may stamp him as different from the normal, has not been so well-known.

A great deal has been written about the relation of glands to personality. Unfortunately most of this is fiction, or at the best, a gross exaggeration of facts. But from the few kernels of wheat that can be separated from the chaff, we do find that disturbances in the functioning of the ductless glands may produce changes in the personality make-up of the individual of such a nature as to prevent him from making normal reactions and hence prevent him from making a normal adjustment to his environment.

Everyone is acquainted with the physical anomalies produced as a result of abnormal functioning of the endocrine glands. Giants, dwarfs, excessively obese individuals, and other "freaks" have definitely been classified from the standpoint of endocrine involvement. What has been lost sight of, however, is the fact that coincident with the abnormal physical changes, corresponding abnormal mental changes may also be produced.

The mental changes may be very subtle and affect only the personality make-up of the individual. This is very often seen in cases of Froelich's dystrophy. On the other hand, they may be more marked and show themselves in the form of grosser psychopathological conditions such as feeblemindedness or schizoid reaction types.

In addition to the effects just described, effects that may be considered as direct results of endocrine dysfunctions, there may be indirect effects. This applies to the mental attitude that the individual may adopt toward the physical and mental abnormality produced by the glandular malfunction.

This indirect effect is of tremendous significance as a rule, because it furnishes the motif for the individual's behavior and determines his outlook on life. Unless we recognize this fact we shall be unable to understand the pathological behavior of many children and especially of adolescents.

Bearing this in mind it is not difficult to understand why the adolescent boy who is suffering from eunuchoidism as a result of gonadal insufficiency, should develop a marked feeling of inferiority which in turn leads him to shun his companions, to become morose and shut-in, to feel that he has been cheated and that life is not worth living. Nor is it difficult to understand why the girl who matures sexually at the age of eight or nine as a result of a combined pituitary and ovarian hyperactivity, may develop personality traits and characteristics that very often result in sex delinquency.

The question naturally arises what effect, if any, will endocrine therapy have in these cases? A great divergence of opinion exists regarding the efficacy of endocrine therapy. There are those who deny the efficacy of all glandular products, thyroid extract alone excepted, when given by mouth. This is an extreme statement and is not warranted by clinical results. Recently Greenebaum and Lurie[5] reported a series of 25 cases of hypopituitarism in children that had been treated with pituitary extracts given both orally and hypodermically. From the results obtained, they felt that "pituitary medication is of distinct therapeutic value in the treatment of physical and behavior disorders of children due to hypopituitary states".

Of course all cases will not respond to glandular therapy. Obviously one cannot correct the hyperactivity of a gland by exhibition of glandular extracts. In such cases we must resort either to surgery or to radiation therapy.

Again, in certain cases no potent extract is available. Furthermore, the therapy prescribed is often inadequate both from the standpoint of

dosage and length of time that it is given. It is unfair to expect results to follow immediately upon the institution of treatment. In some cases very large doses may have to be given over a long period of time. Finally, treatment may not be successful because it is commenced too late. In other words, the endocrinopathic state may have already become fixed, as for example, when the epiphyses have fused, no amount of the growth hormone will cause an increase in height.

Many cases, however, if properly selected, can be helped. In these cases as in all other medical cases, successful results are achieved only when the treatment prescribed is based on a correct diagnosis. Endocrine diagnosis is not simple and many failures ascribed to endocrine therapy should really be ascribed to failure to make a correct diagnosis.

Another point that needs to be emphasized is the fact that in those cases where the endocrine dysfunction produces indirect effects as the development of a marked feeling of inferiority, the glandular therapy may have to be supplemented with other therapeutic measures such as psychotherapy and social therapy.

The following case reports are presented to illustrate the foregoing remarks:

Case 1—G. M., a white boy, age 15 years and 6 months, was referred to the Child Guidance Home by the Juvenile Court because he had stolen money repeatedly from his parents and relatives and friends.

Onset: According to the parents, the boy first started to steal about six years previous to his admission to the Child Guidance Home. At that time he took money from a purse in which his father had left money which he had collected for an insurance company. From time to time, the boy varied the procedure by stealing money from relatives and friends. Lately he had begun to borrow money (which he did not repay) from his teachers at school. Various disciplinary measures had been tried but all to no avail.

Personal History: Medical: G. was a full term baby—delivery was instrumental. Development was normal. There was no delay in teething, walking or talking. He had the ordinary diseases of childhood. His parents noted that for many years, the boy has had an unusually large appetite and tremendous thirst.

Education: The boy entered kindergarten at the age of five years. At present, he is in the second grade of high school. His academic progress is satisfactory. His conduct is good and the only trouble he has given has been borrowing (?) money from the teacher.

Personality Traits and Disposition: According to the mother, G. is a kind, friendly, easy-going boy, well-liked by his companions. He is unselfish with his possessions. He enjoys reading and playing the piano. His interest in athletics is interesting in that he likes to watch baseball and football games and other sports but does not like to participate in any game in which he has to be very active.

Social Background: (A) Heredity—There is nothing in the family history that is pertinent to the case. (B) Home Situation—The environmental factors are of the best. The parents are understanding and the atmosphere in the home is harmonious. The only discordant note in the home is due to the patient's delinquencies.

Physical Examination: With the exception of the fact that the boy was over-height and markedly overweight, the physical examination was negative.

Dental Examination: Mouth hygiene fair—routine prophylaxis recommended.

Visual Examination: Negative.

Neurologic Examination: Negative.

Endocrine Examination: The boy was 64½ inches tall (average height for age 62½ inches) and weighed 171½ pounds (correct weight for height and age 122 pounds). In other words, he was 49½ pounds overweight and 2 inches above the average in height. His span was 4 inches greater than his height, being 68½ inches. His fingers were long and tapering, and the extremities warm, moist and cyanotic. The pelvis was broad and he was knock-kneed. This in conjunction with the excessive amounts of fat which were deposited chiefly over the breasts, hips, and abdomen gave to the skeletal structure a typically feminine appearance. This effect was heightened by the fact that the skin of his face was smooth and fair, and high-colored, and by the fact that his voice was high-pitched. The genital organs were normal but there were no signs of any of the secondary sex characteristics. Roentgenograms of the skull and centers of ossification showed a normal sella turcica and a moderately accelerated bony development. There was an increased sugar tolerance and the basal metabolism reading was minus 15.0 per cent. The total and differential blood count was normal and the blood Wassermann was negative.

Psychometric Test: On the Stanford Revision of the Binet-Simon test, the boy received an intelligence quotient of 92. This rated him low in the group of children of average mental ability. No significant trend was noted in his successes and failures.

Conduct Reactions: When the boy was first admitted to the Child Guidance Home, he told the matron with tears in his eyes that he loved ice-cream above everything else in this world and he could not resist stealing in order to get plenty of it. He said that he had a craving for all sweets but that ice-cream was his favorite. The boy was friendly, cheerful, easy-going and tractable but withal lazy and sluggish. He talked a great deal but his manner was not an aggressive one. He got along well with the other children. At first, he tried to dominate them, but it could easily be seen that he was not a leader and had little force or aggressiveness. The boy's appetite was enormous and he drank huge quantities of water. He complained of headaches very often. There was no eneuresis. It was difficult to arouse the boy in the morning. The report of the manual training teacher was very interesting. According to this report, the boy had no interest in manual work. He was afraid to soil his hands and always wanted to sit down to do his work. His actions at times were very effeminate.

Diagnosis: The boy's stealing is due directly to a specific endocrinopathic state, namely dystrophy adiposo-genitalis with accelerated bone growth, the so-called atypical Froelich's dystrophy. As a result of the pituitary deficiency,

the boy had a tremendous craving for carbohydrates and fluids. In order to satisfy this craving he needed a great deal of money with which to buy food. Stealing was the solution to his urgent need for money. The boy's peculiar personality traits, laziness, sleepiness, mental sluggishness, lack of aggressiveness and effeminate actions, are also due to the pituitary involvement.

Recommendation: Glandular Therapy.

Results: The boy was given extract of the whole pituitary gland, Gr. 2, three times a day. He was under observation for a year and a half. During that time he gained two and a half inches in height and lost 38½ pounds in weight. About a month after treatment was commenced, the secondary sex characteristics began to develop, although his voice did not change in pitch until much later. Coincident with the return of his appetite to normal, the stealing stopped. However, the progress of this case was not uniform. During the period of observation, there were several lapses from the path of righteousness. These lapses always occurred when he failed to take his medicine. It is interesting to note that coincident and coextensive with these lapses, there was always an immediate gain in weight.

COMMENT

This case illustrates very clearly the causal relationship between an endocrine deficiency and delinquent behavior in the form of stealing. The vicious circle produced by the endocrinopathic state can be easily demonstrated. As a result of the pituitary deficiency, the boy had an abnormal appetite and thirst over both of which he had no control. The urge to eat and drink was elemental and imperative and had to be satisfied at all costs. His hunger was not appeased by the food given him at home. These were insufficient to satisfy his voracious appetite. He looked elsewhere. The other sources of supply were the candy store and the bakeshop. He needed money to obtain food at those places but the parents, to whom he naturally turned, refused to give him money for this purpose. The urge for food, however, was acute and the boy solved his problem by stealing the money which he needed. At first he confined his depredations to his own home but later began to steal from his relatives and friends and finally began to borrow (?) money from his teachers. Disciplinary measures were of no avail. Obviously such measures were doomed to failure. No amount of persuasion, corporal punishment or even commitment to a reformatory could overcome the boy's abnormal craving for food. The pituitary deficiency caused the boy to have an abnormal appetite and this in turn was responsible for his anti-social behavior. No improvement in the latter could be expected until the glandular deficiency was overcome.

Case 2—V. G., a white girl, age 11 years, was referred to the Child Guidance Home by the Juvenile Court. This girl was originally referred to the Juvenile Court by the attendance officer of the Board of Education because of truancy and because of obscene love letters which were found in her possession by her teacher. The letters were not only obscene, but they were emotional in the highest degree. In one letter there was a description of how she made the acquaintance of a certain boy. According to the letter she was looking through the window of her bedroom when the boy passed on the opposite side of the street. Their eyes met and it was love at first sight. It was at once realized that this was a fabrication as the windows of the girl's bedroom did not face the street. In addition, the teacher felt that there were no boys in the classroom capable of writing letters couched in such perfect language. The girl was accused of writing the letters to herself. She finally admitted the charge.

Onset: For a year previous to her admission to the Child Guidance Home, the girl had begun to show antisocial reactions. Whereas before she had always been a sweet and tractable child, helping her mother in the household tasks and doing exceptionally well at school, now she refused to do anything at home, quarreled constantly with her mother and spent the greater part of her time alone in her room, apparently day-dreaming. Her school work also suffered, the girl being indifferent and inattentive. It was very difficult to make her take part in the family functions, the girl preferring to be alone. She also became slovenly about her person and room.

Personal History: V. was born at seven months and weighed 14 pounds. She was bottle-fed. She talked at 14 months and walked at 16 months. With the exception of measles and chickenpox she was free from physical diseases. She has suffered from eneuresis from infancy up to the present time. In addition she complains of frequent headaches.

Sexual Development: Menstruation was established at the age of nine years; less than three weeks elapse between periods and the flow is very free. She first learned about sex matters from a girl friend. This was around the time of the establishment of her menses. In addition, she obtained copies of very trashy and lurid magazines, supposedly dealing with love. These magazines were left at her home by a neighbor. Following the reading of these stories she began to masturbate. In this matter she went to extremes.

Education: At present the girl is in the sixth grade. She has never repeated a grade. Up to this year she had received nothing but A's on her report cards, but this year her work has fallen off considerably. She claims that the school work is very uninteresting. She shows considerable talent in writing.

Social Background: (*A*) *Heredity:* The only point of interest in the family history is that all members of the family on both the maternal and paternal sides are very big and powerful, all weighing about 250 pounds. This can be traced back for three generations. (B) *Home Situation:* The family is independent financially. Socially and intellectually the parents are of the average type. The home and the environmental influences are of the best.

Physical Examination: The physical examination was entirely negative except for the fact that the girl was overweight and overheight.

Visual Examination: Slight degree of myopia.

Dental Examination: Nothing abnormal present in the teeth.

Neurologic Examination: Negative.

Endocrine Status: The subjective symptoms were as follows : The girl drank a great deal of water and had an enormous appetite and was

especially fond of sweets. She perspired freely. Her menstruation was established at nine years and less than three weeks intervene between periods. She had always suffered from eneuresis and frequent headaches. Objectively, the girl was 64¼ inches tall (average height for age 53) and weighed 151½ pounds (correct weight for height 111 pounds). In other words, she was forty pounds overweight and eleven inches taller than the average girl of her age.

The skeletal overgrowth was most marked in the case of the long bones, but the acral bones also shared in the over-development. The fingers were long and tapering, the palms square, and there was a marked distribution of fat over the breasts, abdomen, and hips. The face was broad and of the acromegalic type. Prognathism was marked and there was a tendency toward a saddle nose. The teeth showed no pathology. There was a marked cyanosis of the skin of the upper extremities. The hair distribution was widespread but normal. The thyroid gland was slightly but uniformly enlarged. The genital organs were normal. Hair was present over the pubes. The result of the basal metabolism was plus 35.0. The blood Wassermann was negative.

Roentgenographic Findings: The sella turcica was normal both in size and shape. There was a marked general bony over-development. The bony development corresponded to that of an individual 15 years of age. The epiphyseal lines of the long bones were still open. The sesamoid bones of the hands were well-developed. The tip of the olecranon process had already fused with the shaft. The same was true of the tuberosities of the humerus and femur.

Psychometric Test: Although only 11 years, 10 months old at the time of the psychological examination, the girl made a mental age of 16 years and 9 months. Her intelligence quotient was therefore 142, that of a person of very superior intelligence. The girl's intelligence quotient was 148 if Terman's procedure for the correction of the inadequacy of the Binet Scale in the upper levels were used. The girl made a basal age of 12. She succeeded in all the tests at the 18-year level. Her responses were prompt, exceptionally well-expressed and accurate. She had an unusually good vocabulary. On the graded opposites test, a test of language ability, she rated as a superior adult.

Conduct Reaction: When first admitted to the Child Guidance Home, the girl had little to do with the other children. She did not take part in their games. When questioned regarding her attitude she claimed that she was so much larger and heavier than the other children, although of the same age, that she felt that they laughed at her. She felt that her size was something to be ashamed of. Hence, rather than be laughed at, she preferred to sit alone and read and daydream. She exhibited an extreme degree of emotional instability, which was startling in the rapidity of its changes. She passed from a high degree of elation to a severe state of depression in an incredibly short space of time. She was extremely sensitive about her age and was reluctant to discuss it, blushing and giggling and looking very miserable when the subject was broached. She also resented correction. She wet the bed frequently. She complained of headaches. She admitted that her ambition was to be a writer and she was willing to work very hard to accomplish this. She received the following rating on the personality chart: Temperamentally she was truthful, sanguine, and more or less phlegmatic. She was fairly tractable. Mentally she was alert, but emotionally she was highly unstable.

Diagnosis: Maladjustment due primarily to a pluriglandular endocrinopathy involving principally the pituitary gland and the gonads (ovaries). (In the case of the pituitary gland the anterior lobe is hyperactive while the posterior lobe is hypoactive).

Recommendation: (1) Endocrine Therapy. (2) The girl should be given an opportunity to advance rapidly in her school work so that she can reach a grade where she will find herself among children more closely approximating her in physical and intellectual development.

Results: Upon being told that an effort would be made to reduce her weight, the girl became highly enthusiastic and cooperative. She began to confide more and more in those interested in her and it was not very long before she told of her pent-up emotions as a result of her reaction to the attitude of her schoolmates to her huge size. As she expressed it, she was constantly having "hurt feelings". She was given ½ grain of the extract of the posterior lobe of the pituitary gland three times a day, and during the time she spent at the Home she lost 13 pounds. Her headaches disappeared and the eneuresis also stopped. In addition to the glandular therapy, she was sent to summer school and was permitted to skip several grades. At home, her adjustment became perfect. The girl was happy and contented and did not resort to day-dreaming any more. She graduated from high school with honors. She was married at the age of 15 years, and a year later gave birth to a girl. Her life at present is normal in every respect.

COMMENT

This case is of peculiar interest in that it brings out both the direct and indirect effects of an endocrine dysfunction on the physical and mental makeup of the individual. In addition to the marked physical and sexual precocity, the case illustrates the development of a psychoneurotic condition and its arrest with the recognition and treatment of the underlying endocrine cause.

Here is presented a child of 11 years who was so big that she could easily have passed for a girl of 17 years or older. Physically and mentally, she was an adolescent; chronologically, however, she was only a child. At the age of nine when her playmates were still interested in dolls and nursery rhymes, she had already begun to menstruate. It therefore can be easily understood why she refused to go in swimming with her classmates. Furthermore, it is not to be wondered at that her companions did not invite her to their parties. She was too big for their games. On the other hand, the older boys and girls had nothing to do with her because in spite of her huge size she was but 10 or 11 years old and in the corresponding grade of school. Thus the girl found herself a misfit and a social outcast. Like all normal girls she craved the companionship of her kind. She wanted to go to parties, to be popular

and to be invited by her friends to the movies and other places of amusement. But because of the discrepancy between her chronological and anatomic ages, she was denied the expression of this normal craving. With her superior intellect (I.Q. of 142), she soon found an outlet for her longings. She began to day-dream and in the world of dreams, of unreality, she lived the life she desired to live. Here she found refuge from the jeers of the world as well as pleasure in her phantasies. More and more she was becoming a shut-in type of individual, losing, little by little, all contact with reality. She wanted to be alone in a world of her own making where everything was pleasant and to her liking. Hence her peculiar conduct when forced to face real issues, such as the home situation and the school.

One can only surmise what abnormal mental condition would finally have developed had not the causal relationship between her physical and mental precociousness and the endocrine disturbance been recognized. It should be noted that because of the presence of both direct and indirect effect of the endocrinopathic state, glandular therapy had to be supplemented with social therapy in the nature of proper academic placement.

SUMMARY AND CONCLUSIONS

(1) Statistics at the Child Guidance Home show that in a series of one thousand cases of problem children studied at the Home, endocrine disorders were responsible for the behavior difficulties in more than 9 per cent of the cases. This is a startlingly large percentage and demonstrates the need for a thorough routine endocrine study of all psychopathological conditions of childhood.

(2) Disturbances in glandular functions may lead to abnormal conduct reactions either directly or indirectly; directly as in cretinism where the lack of thyroid secretion is responsible for the mental retardation and in dystrophy adiposo-genitalis where the lack of pituitary secretion may produce general physical and mental sluggishness or peculiar personality traits; indirectly as in those cases in which as a result of physical malformation such as gigantism or dwarfism, the individual develops abnormal mental attitudes and reactions that make normal social adjustments very difficult if not entirely impossible.

(3) In many of these cases, a correction of the behavior difficulty may be brought about through the correction of the endocrine disturbance. In some cases the endocrine therapy may have to be supplemented by other measures, such as psychotherapy and social therapy. This is especially true in those cases in which the endocrine disorder has produced indirect as well as direct changes in the psychophysical make-up of the child.

(4) It should be remembered that all endocrine disturbances cannot be corrected by means of glandular therapy. This is especially true in cases of glandular overactivity.

(5) Finally, glandular therapy to be successful, must be based on a correct diagnosis. Furthermore, both the dosage and the length of treatment must be determined for each case separately. Many cases that otherwise would have been helped fail to be benefited because of insufficient dosage and insufficient length of treatment.

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POST-PARTUM CARE

By WM. D. FULLERTON, M.D., F.A.C.S., CLEVELAND, OHIO

THE puerperium may be divided into three stages: 1. Immediate, to cover the period the patient remains in the delivery room; 2. Intermediate, the time she is confined to the hospital or her residence; and 3. Late, to extend over at least a year, if necessary, following the birth of the child. For want of space we will limit the following remarks entirely to a discussion of late post-partum care.

LATE POST-PARTUM CARE

Before leaving the hospital, the patient should be fully instructed about her routine care and advised to report any untoward symptoms at once. It should be insisted upon that she report for her thorough post-partum examination about six weeks after delivery. At the post-partum examination a specimen of urine should be examined and the blood pressure taken. Special and repeated attention should be given those cases who previously showed any indication of renal involvement. With persistence of albumin and casts, and an elevated blood pressure, a chronic nephritis should be suspected, and appropriate care recommended, and such a patient should be

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warned against future pregnancies and advice given for contraception.

Persistent backache is a common complaint. This is more often due to a relaxed or strained pelvic girdle with the major discomfort centered in the sacro-iliac joints, than to abnormal positions of the uterus. A straight, non-elastic canvas or webbing belt, about four inches wide, closed with two buckles and tightly applied around the hips just above the trochanters gives great relief. It should be worn constantly for several months, being slightly loosened at night.

If there has been any pyelitis or other renal complication, or cystitis during the pregnancy or after delivery, special and appropriate care should now be given the urinary system. Such conditions are much more easily cured in the non-pregnant state, and they frequently recur in subsequent pregnancies and may lead to disastrous results.

The perineum and vaginal walls should be carefully inspected and palpated and their condition and state of healing noted. Granulations or superficial infections should be appropriately dealt with, and if any undue relaxation, cystocele or rectocele exists, the patient should be informed as to the advisability of future repair work. The anus should be examined for hemorrhoids and fissures, and if present, the patient instructed as to their care.

Bi-manual examination will reveal the size and consistency of the cervix and fundus, and the position of both. In at least 30 per cent of all cases, the fundus will be found in a posterior position, more usually a retroflection, in which position it is very apt to be enlarged, soft and boggy—sub-involuted, and accompanied by a feeling of weight and pressure in the pelvis, a persistent lochial discharge and frequently with backache. In such cases, the fundus should be brought forward and a properly fitting Smith-Hodge pessary introduced to maintain this position for eight to twelve weeks. The knee chest position may be advised as an accessory aid, and continued hot douches twice daily will hasten involution.

May I be permitted at this point, in discussing post-partum care of the cervix, to digress somewhat from the immediate subject, since the importance of such care and its relationship to subsequent carcinoma in this area is most significant.

The reduction and eventual elimination of deaths from cancer, is the greatest single problem before the medical and allied professions today. Cancer is today the second greatest cause of death. Not less than 150,000 persons die annually in the United States from this cause, and the rate is increasing by two and a half per cent each year.[1] Thirty thousand women, most of them in the prime of life, die each year from pelvic cancer, of which 25,000 are of the uterus. One woman out of every eight who reaches the age of 35 years dies of cancer.[2] About 90 to 95 per cent of uterine cancer is primarily in the cervix, and 5 to 10 per cent in the fundus. Also about 95 per cent of cervical cancers are in multipara, and only 5 per cent in nullipara.[3] These figures are extremely significant in the light of what we know relative to the origin of cancer.

Cancer never starts in healthy tissue. It has a single point of origin. Chronic infection and long continued irritation, even up to 10 or 12 years, almost always precede cancer development. What if such conditions are eliminated? Bossi[4] reports 7,000 cases in which the cervix was cared for by amputation, and Hunner[5] 2895 cases treated by cautery or amputation and followed for 10 years, in which not a single case of cancer developed. Pemberton and Smith[6] report 5900 cases similarly treated with only five cases developing cancer later, and they state that in 669 cases of cancer of the cervix, only 12 had previously had any cervical attention.

From the evidence presented, it is perfectly apparent that cervical trauma coincident to childbirth, with the subsequent chronic infection and irritation, is a tremendous factor in the later development of cancer in this location. At least 50,000, or one-third of all cancer deaths, could be prevented annually in the United States by proven methods of treatment, if the diagnosis of cancer were only made earlier and treatment promptly given.[1] But passing over this phase of the subject, how much more effective is the prevention of cancer by the elimination of such factors as lead to its development. There is no greater field with such large rewards than this preventive endeavor. It behooves all medical men, but particularly the obstetrician, to give to the cervix the care and prophylactic attention which it requires, if we wish to reduce the ravages of cancer in this location.

To resume now the post-partum care of the cervix. At the post-partum examination the cervix should be examined especially for any unhealed lacerations or evidences of infection. All deep tears should have been sutured immediately after delivery. If these or any slight lacerations are not healed, linear cauterization usually hastens healing. This should be repeated after a month or six weeks, if necessary, but attention should never be relaxed until the entire cervix is perfectly epithelialized, without any eversion or erosion or evidence of infection. Unless this can finally be accomplished by such means within six months, the importance of the matter should be carefully explained to the patient and she should be advised of the necessity for further attention, deep cauterization, trachelorrhaphy or amputation, as the case may require. Cauterization or trachelorrhaphy are much preferable to amputation, which should not be done in young women

expecting more children. Amputation is the operation of choice for older women after or approaching the menopause. At the time of any such repair work, the perineum should be repaired if at all relaxed, and any hemorrhoids removed.

SUMMARY

Post-partum care may be divided into three stages, immediate, intermediate, and late.

Watchful supervision and careful instruction to the patient is required in each for her immediate safety and comfort, and for her ultimate welfare.

Special stress is laid on the immediate care of the perineum and cervix; on the intermediate care of the bladder; and on the late care of the cervix. Chiefly by the latter, may we quickly reduce the subsequent development of carcinoma in this region.

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SOME REMARKS ON THE PHARYNGEAL LYMPHATICS:

And the Indication for the Tonsil and Adenoid Operation

By HUGH GIBSON BEATTY, M.D., COLUMBUS, OHIO

GENERAL REMARKS

IN the consideration of abnormalities of the principal lymphatic structures of the pharynx, one should not fail to note the condition of the other closely associated and connected masses of similar tissue in this locality. Frequently a primary or secondary reaction in one or more of the lymphatic structures of the pharynx may be noted. As will be shown later in this discussion, it is of great importance in certain patients to note whether or not this involvement is single or multiple, whether or not the reaction is due to infection, and, if so, whether it is intrinsic or extrinsic, or due to some other influence active in the system.

The tonsil frequently presents a problem to men engaged in any of the various branches of medicine. Not so many years ago the profession was so enthusiastic over the good results obtained by tonsillectomy in certain cases that it was resorted to too generally, and this naturally led to some disappointments. The first inclination may be to say "have your tonsils removed now", but this has been proven in some instances to have been far from good advice.

We find physiological enlargement of the tonsil before the age of puberty and changes later in life due to infection and other influences. Many different diseases known to be caused by focal infection can be affecting a patient who has tonsils. If such a patient has infected tonsils, do not feel too confident at the first glance that the tonsil is the sole source of infection, but look over the whole upper respiratory area in the process of a general physical check-up of the patient before giving advice. Of course, the extent of this study varies with the age, clinical findings, and diseases which we hope to alleviate by operation.

The palatine tonsil is the largest one of the Waldeyer ring of lymphoid structures in the pharynx, and the adenoid is next. Because of their structure, anatomical size, and projection into the pharyngeal cavity, they are more exposed and liable to infection. The palatine tonsil, when diseased, is more often associated with constitutional disturbances and therefore is the most important when considering the lymphoid tissue of the pharynx as a focus of infection. We must, however, not forget the lateral pharyngeal lymphoid masses, the numerous groups of lymphoid nodes on the posterior pharyngeal wall, and the lingual tonsils as possible foci of infection. The adenoid mass usually causes trouble by oversize, but must not be ignored as a possible source of infection. It is bad judgment to remove infected tonsils as a source of systemic absorption and leave an infected adenoid or other infected pharyngeal masses. This is too frequently done in tonsillectomy done under local anesthesia.

A few years ago we ran a bacteriological examination of a series of tonsils and adenoid removed from patients suffering with systemic disease, the result of the absorption of bacterial toxins. Each tonsil and the adenoid were sent to the laboratory in separate sterile glass containers. In each instance, bacteria found in one or

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From the Department of Oto-Laryngology of Mt. Carmel Hospital, Columbus, Ohio.

both palatine tonsils were found in the adenoid.

In the presence, let us say, of a known diseased tonsil, the careful doctor will have three main thoughts to consider:

(1) Will the patient survive the operation, having in mind such disorders as a severe heart or kidney disease, or other systemic involvement where surgery is more than the ordinary risk, such operation usually being advised by the internist when the tonsils are thought to be the cause of the disease.

(2) Will removal or treatment of the tonsil lower the patient's resistance too much or otherwise give the disease, which we had hoped to relieve, superiority over the body resistance to it? This question is particularly pertinent in cases of tuberculosis, severe or chronic cardiovascular or renal disease, rheumatic fever, chronic arthritis, etc. If the operation is undertaken, the method in which the palatine tonsil is removed is important.

(3) Will the operation, if recovery is uneventful, do what we expect it to do and what we encourage the sufferer to expect? There are times when the result cannot be truthfully foretold. If the complication is one that, in a fair percentage of cases, is relieved or improved by the removal of infected tonsils or abscessed teeth, the operation is advised. However, the following points are explained to the patient with complicating lesions:

(A) The removal of definitely infected tonsils must be a benefit in removing this source of toxins to the already involved areas and possibly preventing complications in uninvolved structures.

(B) That the permanent organic lesion will not be removed by the operation, but that its progress from this source of infection will be stopped.

(C) Too much in the way of complete recovery should not be expected.

(D) Good effects may be slow in convincing the patient that operation was worth while.

As has been said, in many instances these questions cannot be answered. Sometimes they can be answered by Yes or No.

Most men justly feel that when a tonsil is so affected by disease that it cannot perform its normal function it is a detriment to the patient and should be removed, if the operation can be safely done. We do not advocate the removal of a palatine tonsil just because it is a tonsil. If, on the other hand, an adenoid mass is of any notable size, removal is always considered and usually advised. This radical attitude towards the adenoid is taken because of its effect on the ears and tendency to produce intranasal and pharyngeal irritation. When enlarged and covered by normal epithelium, there is an excess of secretion, often thick tenacious mucus. When the surface epithelium, through infection and inflammation, changes to the flat variety, it becomes more a focus of infection and irritation to the surrounding mucosa and lymphatics of the nasopharynx and surrounding areas. This is mentioned because it is often overlooked in the adult patient.

WHEN DOES A TONSIL MANIFEST ITSELF CLINICALLY

Attention is usually directed to the tonsils for one or two reasons: (1) When there is great enlargement through simple hypertrophy.

(2) When they are the seat of infection, primary disease or reacting to some constitutional disease.

Possibly in the child, evidence of the tonsil as the cause of the symptoms complained of is more easily obtained. If the tonsils are not noticeably infected and are only moderately large but the adenoid large, obstructive, covered with thick mucus or having a low grade inflammation, the latter is probably causing the most trouble. If in such a case the child is five years of age or under, the troublesome adenoid alone can be removed. The argument against this procedure is that sooner or later the tonsils will have to be removed or the parents do not want a second operation. However, in many cases we feel that this advice should be followed.

Tonsillectomy in children five years of age or younger is contraindicated except in certain instances where the need of removal is perfectly clear.

LARGE TONSILS

Enlarged tonsils may be observed at nearly any age, chiefly up to the age of puberty. During this period the increase in size is due chiefly to the lymphoid tissue or cellular elements. Such tonsils are soft and while they may be of a red color, this is not normally due to inflammation.

After puberty, if the size persists or the tonsil again enlarges out of proportion to the patient's age, the size is due to an increase in connective or fibrous tissue, more than the cellular elements. A rapid or sudden increase in the size of the tonsil in adult life should be viewed with concern as will be later explained.

The size of the tonsil cannot always be determined by the amount of tissue visible in the pharynx, as a submerged tonsil may prove to be quite large when exposed.

THE QUESTION OF FUNCTION

The function of the tonsil is not definitely known. For a long time, along with other lymphoid structures of the throat and the cervical glands, the tonsil has been considered a protective organ against bacterial invasion. This idea is based on the reaction in the tonsil during pharyngeal inflammation and the resulting adenitis when the tonsil is infected. It was formerly thought the tonsil formed an internal secretion and that removal would be dangerous. Today there is a thought among some clinicians

that up to five years of age this function may exist. Others believe that the tonsils, together with the other subepithelial lymphoid tissue of the pharynx and intestines, are the site of a certain immunization of the body against organisms entering the respiratory and digestive tracts. One could go on at length and still not settle the question of the function of these structures.

DISEASED TONSILS

When a tonsil or adenoid has once been the site of an acute inflammation with infection, there always remain some areas in the structures which harbor bacteria and contain debris. These areas vary in that they may be large or small, single or multiple, and placed at various levels in the tonsil. These variations are important and should be considered along with the question whether or not the area outlets to the tonsillar surface are constricted, because these conditions produce systemic absorption of the bacterial toxins.

When a tonsil has become chronically infected, it must be regarded as at least a potential source of danger. We occasionally see robust, apparently healthy adults who have infected tonsils, yet who do not seem to show systemic effects of the absorption. That absorption is actually taking place, we do not doubt. Sometimes a blood count will show a slight leukocytosis or there may be a slight daily rise in temperature, or some other systemic manifestation of toxin absorption which the patient has ignored or attributed to something else. However, should this patient's resistance be lowered from some other cause, local tonsillar symptoms may appear, and possibly be accompanied soon after by reactions of varying severity in distant structures, attributive to a focal infection. In such a case, the tonsillar infection can reasonably be the cause. It is often a problem when we find adults with tonsils from which we cannot express septic secretion, in spite of the fact that both the history and the appearance of the tonsils indicate a low grade infection. Such patients must not be lightly considered, but, if not operated, should have periodic observation of the tonsils and general health.

It would seem that a physician confronted by a patient with either of the above types of tonsils, after a careful checking and elimination of other possible sources of infection, would be using sound logical judgment if he advised tonsillectomy. Furthermore, the removal of such a tonsil possibly would prevent the occurrence of an acute pharyngeal infection and its effect on some distant body structure which would suffer a permanent lesion. If the patient has an involvement of the heart, kidney, joints or ears due to a septic tonsillitis, it is doubtful if any such involved organ ever completely recovers. Many, we know, do not, even though the lesion may not increase.

LOCAL SIGNS OF INFECTED TONSILS

In adult patients, the history of subjective throat manifestations of tonsillar infection may be negative. In fact, patients will often say "my tonsils do not trouble me; how can they be causing trouble elsewhere".

As mentioned elsewhere in this discussion, the size is not so important as the character and contents. Chronic congestion or redness of the anterior pillar and adhesions of the posterior pillar indicate present and past bacterial activity within the tonsil. Retraction of the anterior pillar and pressure on the tonsil will often demonstrate an unsuspected size of the tonsil as well as a surprising amount of septic secretion or caseous detritus. This can be easily done with one instrument, using "Colver's retractor for examining tonsils", as made by Victor Mueller and Company, Chicago. Often this maneuver will throw into view cavities and wide mouthed crypts showing chronic parenchymatitis.

The diagnosis of an active tonsillar focal infection distributing toxins to the system can be made in the presence of the following findings: 1. Chronic congestion of anterior pillars. 2. Chronic irritation of posterior pharyngeal lymph nodes. 3. Septic secretion or material in the tonsil. 4. Inflammation of tonsillar cavities or crypt mouths.

Should the upper deep cervical lymph nodes, especially one just behind the angle of the mandible, be tender and enlarged, this, in the absence of other causes for the adenopathy, is an additional diagnostic sign.

While on the subject of infected tonsils, let us review the bacteriological work done for us four years ago in the laboratory of Mt. Carmel Hospital on a series of tonsils. The study was based on about two hundred and fourteen patients operated on because of tonsillar infection. As each tonsil was cultured separately, four hundred and twenty-eight tonsils were studied. Of this series, two hundred and twelve tonsils showed a pure culture of one organism, and the remaining, two or more.

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Table I. ORGANISM OBTAINED IN PURE CULTURE

Organism	Numerical Incidence	Percent Incidence
Streptococcus Viridans	78	18.3
Strep. Hemolyticus	40	9.4
Strep. Anhymolyticus	13	3.0
Staphyloccus	54	12.6
Mic. Catarrhalis	19	4.4
B. Coli	3	0.7
Mic. Tetregenus	2	0.5
B. Fecalis Alk.	1	0.2
Diphtheroids	1	0.2
Dip. Grassus	1	0.2

That is, 18.3 per cent of the four hundred and twenty-eight tonsils examined showed streptococcus viridans alone; 9.4 per cent showed streptococcus hemolyticus alone, etc. Table II records that 39.4 per cent, in addition to this 18.3 per cent, had streptococcus viridans along with one or more other organisms; 20.9 per cent, in addition to the 9.4 per cent, harbored streptococcus hemolyticus along with other organisms, and so on through the tables.

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Table II. TOTAL NUMBER OF ORGANISMS OBTAINED

Organism	Numerical Incidence	Percent Incidence
Streptococcus Viridans	168	39.4
Strep. Hemolyticus	89	20.9
Strep. Anhemolyticus	54	12.6
Staphyloccus	170	40.0
Mic. Catarrhalis	42	10.0
Pneumococcus	4	0.9
B. Coli	5	1.1
Mic. Tetragenus	2	0.5
B. Fecalis Alkaligenes	1	0.2
Diphtheroids	3	0.7
Dip. Crassus	1	0.2
Mic. Pharyngis Siccus	4	0.9
Friedlander's Bacillus	3	0.7

PRIMARY DISEASES IN THE TONSIL AND CONSTITUTIONAL DISEASES AFFECTING THE SIZE OF THE TONSIL

Tumors of the tonsil occur as benign and malignant growths. They are practically always unilateral and should easily be distinguished from hypertrophy. Surgery is the treatment of choice. However in malignant growths, several factors must be carefully considered before any form of treatment is advised. A close study of a sufficiently large piece of the mass will determine the form of treatment which should be applied to the particular growth encountered. In tumors suitable for surgery, the operation must be done early, radically, and often through an external approach. Certain types of cancer are highly radio-sensitive and in this type, surgery is not indicated. This applies to many malignant tumors of the tonsil, and radiotherapy offers, in such instances, better results than surgery or electrocoagulation. So, in selecting the form of treatment, the following points must be considered:

(1) Type and nature of the growths. (2) Location and extent of involvement. (3) Involvement of cervical glands which are connected with the tonsil.

Coutard of France and Berven of Sweden are working and experimenting extensively with radiotherapy in malignancies of the pharynx and larynx. However, the skin reactions in their method of treatment are often so severe that radiotherapists in this country are, in many instances somewhat reluctant to adopt it. Only when the case is inoperable or the type of tumor not surgical, or the growth inaccessible do we employ radium and *X*-ray therapy alone. Cancer of the tonsil is always a serious disease because of its location and because in many cases the growth is well established before cancer treatment is begun.

Tumors and cysts in the peritonsillar space are encountered and must not be mistaken for intrinsic tonsillar involvement. This error has been made because of the position and appearance of the tonsil in such patients. Unilateral or bilateral enlargement through the influence of some systemic disease is now and then observed. It is necessary to recognize these occurrences as surgery might be fatal. The involvement of the tonsil in acute leukemia is a good example.

If the tonsil, usually along with some or all of the other pharyngeal lymphatics, has shown some unexplained and fairly recent enlargement, congestion, or other changes, a cause elsewhere in the system should be carefully looked for before our principal attention is directed to this locality.

Primary tuberculosis of the tonsil is not diagnosed as such before the tonsil is removed, but microscopically. Writers from various localities and countries report different percentages of occurrence. Dean[1] of St. Louis reports that it is rarely found in routine practice and this is our conclusion. The average incidence as reported by men engaged in the practice of laryngology is about 1 per cent. "However, routine complete examinations of extirpated tonsils would no doubt increase the incidence." [2]

The percentage increases if we include patients with chronic adenitis of no known cause and more especially patients having pulmonary tuberculosis. The advisability of tonsillectomy in the tuberculous patient with chronically infected tonsils cannot be discussed in this presentation more than to say that it is more often a help to to the patient than has been thought in the past and in selected cases caused little or no deleterious reactions.

Tables prepared by Newhart[2] reporting the incidence of tuberclous tonsils in the routine practices of various men are of interest. The patients were children and adults, the diagnosis having been made in most instances by microscopic section.

Table III shows the incidence of tuberculous tonsils in routine tonsillectomy.

Newhart

TABLE III

INCIDENCE OF TUBERCULOUS TONSILS IN ROUTINE TONSILLECTOMIES

Author	No. Cases	TBC Tonsils	Per Cent
Weller (10)	8,967	204	2.35
Wilkinson (11)	10,000	52	0.52
Crowe, Watkins and Rothholz (12)	1,000	46	4.60
Judd (13)	1,000	23	2.3
Sewell (14)	772	30	3.9
Barnes (15)	150	3	2.0
Lewin (16)	200	9	4.5
Robertson (17)	232	19	8.0
Willis (18)	108	9	8.3
Mullin (19)	400	17	4.25
Hodenpyl (20)	200	1	0.5
Morris (21)	2,321	39	1.7
MacReady and Crowe (22)	3,260	138	4.23
Cornell (23)	2,336	35	1.49
Total	30,676	625	2.03

Numerals following author's name refer to Newhart's bibliography.

Table IV shows the frequency of tuberculosis of the tonsil in patients suffering with pulmonary tuberculosis in a tuberculosis sanatorium.

Newhart

TABLE IV

INCIDENCE OF TUBERCULOUS TONSILS IN RELATION TO STAGE OF PULMONARY TUBERCULOSIS

Stage Disease	No. Cases	No. Tonsils TBC	Per Cent
Far advanced	54	31	57.4
Moderately advanced	34	15	44.1
Minimal	12	2	16.6
Nonclinical	4	0	.....
Normal chest	8	0	.....
Total	112	48	42.8

RESULTS OF INFECTED TONSILS

We are assuming in this part of the discussion that all other possible portals of infection have been eliminated or are known and that the tonsil itself is being considered as the cause of the systemic diseases.

Large infected tonsils have long crypts often reaching to the capsule. Many are branched and sacculated and may connect with a small cavity containing bacteria and debris. The lymphatics of the tonsil drain into the deeper cervical glands and especially to the carotid gland. Absorption of toxins is favored here by the long crypt or duct having poor drainage. The small fibrous submerged type has many constrictions of the shorter ducts which, in a way, interfere with surface drainage and favor absorption.

You are familiar with the large list of ailments ascribed to an infected tonsil and know that almost any tissue or organ in the human body may be involved. Often the severity of the resulting disease is out of all proportion to the appearance of the tonsil. In fact, we have removed small, atrophic tonsils and found a *very* virulent strain of bacteria. No one can say to what extent a tonsil is involved by macroscopic examination. After removal, carefully taken cultures and microscopic examination will show the true condition of the gland. A culture taken from the surface of the tonsil before removal is not a true index because of oral contamination.

If a child of any age during the course of an attack of septic tonsillitis has a reaction in the ears, sinuses, lungs, kidneys, heart, or joints, the tonsils and adenoid should be considered responsible. Especially is this so if the child has not had scarlet fever, measles or diphtheria; not that tonsillectomy renders the child less liable to diphtheria, but if this disease is later contracted, the pharyngeal reaction and tonsillar absorption is decreased. We well know how extensively the tonsils and adenoid are involved in scarlet fever and measles.

Upper respiratory infections, such as sinus infection and carious teeth, as well as malnutrition, etc., may affect the size of the intrinsically infected tonsils in childhood and must be considered.

Chronic lower respiratory involvement, such as laryngitis, bronchitis, beginning bronchiectasis, are usually due to an upper respiratory infection and the tonsil along with the sinuses should have careful inspection.

Acute focal nephritis in children with blood in the urine occurs especially in streptococcic infection and the tonsil is frequently the source.

Most obstetricians recognize the importance of eliminating focal infections in such structures as the teeth, tonsils, and sinuses early in the pregnancy. Those engaged in the care of patients with dysfunction of the thyroid in whom there is an active focal infection in the oro-pharynx recognize its importance, and, in some instances, advise correction before proceeding with thyroid treatment or surgery.

TREATMENT

The treatment of tonsils which manifest themselves clinically varies in individual cases, as well as with the doctor in charge. The patient is to be carefully considered along with the tonsils. If this is always done, many surgical mishaps and post-operative disappointments will be averted.

Treatment can be divided into: 1. Local. 2. Surgery. 3. Constitutional.

Local treatment has long been in vogue in many forms, such as gargles and applications of the

greatest variety and method of application, medicants locally applied to "sterilize" the tonsil and others to "shrink" the tonsil and adenoid. These measures for the most part are a waste of time; often valuable time.

Suction drainage has been advocated and still is, by some. Considering tonsillar anatomy, we know that one cannot completely "vacuum clean" a tonsil. The forceful suction can rupture the thin epithelial wall of the tonsil in places, so that release of the suction causes a forceful entrance of crypt contents into the parenchyma of the tonsil with resultant increased absorption.

X-ray and radium came along for a short-lived, but good-while-it-lasted method of treatment—good for the radiologist.

Many other forms of treatment with which you are familiar have been tried. However, in this discussion of treatment we cannot pass over, without some remarks on the most recent "fad" in the list of treatments of the palatine tonsil. The method we have in mind has gained more ground probably than any of the other radical measures offered as a substitute for surgery, because it can more easily be placed in more hands than some of the others—and is not limited to members of the medical profession. We refer to "electro-coagulation of the palatine tonsil".

During the past few years, electro-coagulation of the tonsil has been advocated by some as a satisfactory substitute for tonsillectomy. This agent admirably suited to certain procedures has, to its embarrassment, been adopted by some as the major means of treatment of the chronically hypertrophied or infected tonsil. Such terms as "removal", "eradication", "total destruction", etc., are applied to the hoped for results of its application to the palatine tonsil in lieu of surgery.

When first proposed, the method was tried out by many outstanding laryngologists of the country. Today, few, if any, such men use it. Members of other branches of medicine, encouraged by good salesmanship on the part of the electrical equipment companies rather than by the employment of good judgment, began the practice and many are continuing it. Many chiropractors today advertise "bloodless tonsil" operation with the "electric needle", etc.

To the sensible, conscientious doctor, further comment would seem unnecessary.

The "salesmanship talk" usually coined by the equipment salesman, which appealed to the "gullible patient" who may or may not have had a sincere dread of "operation", included such phrases as "painless", "bloodless", "no hospitalization or anesthetic", no loss of time from work", and "just as good as surgery", etc. Frankly a very convincing array of statements and accepted by many patients seeking to avoid "operation". Time and experience, the two old "test tubes" of medicine, have disproved such promises.

In this method, there *is pain;* hemorrhage does occur, and some fatalities are reported, and, except in exceptional instances, infected tonsillar remnants do remain. If confronted by a patient whose general physical condition will not permit a general anesthetic or the shock subsequent to a complete tonsillectomy under local anesthetic, radium, *X*-ray or electro-coagulation may be considered. However, in such a stage of physical decompensation, what can be attained by any method? Certainly, in the long electro-coagulation process, local reaction and absorption of the products of necrotic tissue must be considered as dangerous.

It was hoped that the method would be a safe procedure in types of hemophilia, but severe secondary hemorrhage has freed us from this delusion.

You must bear in mind that electro-coagulation of the tonsil is not being totally condemned when employed by a competent laryngologist, but *is* being given *no* quarter whatsoever when a surgical removal can be done on the patient.

It is only fair to say that no technique is 100 per cent perfect, but sensible and conscientious medical men know that surgery is our nearest approach, when properly done.

One should not be too completely swayed into early experimental channels, taking with us *all* of our patients. We may take some—yes, certain ones safe for the test, or otherwise we remain in the same old rut and the progress of medicine is held up. However, when a sufficient number of competent and reputable men conclude the test is unsatisfactory, it should be discarded. One of my former instructors used to quote, "Be not the first by whom the new is tried, nor yet the last by whom the old is laid aside." The first part of the quotation may be questioned, but if we refer to electro-coagulation as the "old" in the second part, it is a most excellent axiom.

SUMMARIZING THE DISCUSSION OF ELECTRO-COAGULATION OF TONSILS

(1) Electro-coagulation has its place in the treatment of the involvement of certain lymphatics of the pharynx.

(2) It is not the method of election in the treatment of the entire or intact palatine tonsil.

(3) It is not devoid of danger and discomfort.

(4) You should not, by allowing a salesman to tell you how to treat your patients, express an inherent medical weakness.

(5) If you cannot do the operation properly, get a consultant who can, thereby protecting your patient and—retaining the respect of your colleagues.

Roberts[3] in his article "Diathermy in Tonsil Disease" quotes many outstanding laryngologists of the country and concludes:

"The danger of secondary hemorrhage is great."

"There is post-operative pain in the series of treatments."

"Secondary infection, with edema, is always present in some degree, and scar tissue invariably is the end result."

"Diathermy is unsurgical and dangerous in itself, and may be dangerously inefficient from the standpoint of the patient."

"Additional surgical removal is necessary afterwards."

Many other forms of treatment, with which you are familiar, have been tried.

SURGERY

As to surgery in some patients, the particular technique is not as important as the completeness of the removal and the proper time of operation with reference to the patient's condition and age.

In the presence of serious complications, the question of immediate or delayed operation is decided for us by the pediatrician or medical man in charge of the general care of the patient. Aside from the usual well-known pre-operative information regarding blood, urine, heart and lungs, there is frequently further precautionary information desired.

The removal of the palatine tonsils in a child five years of age or under without a very good reason is ill-advised surgery, bad medical advice, and may precipitate operating table accidents or lead to later complications which are laid to the operation.

In young children, tonsils showing simple hypertrophy, large enough to obstruct the pharynx in eating and breathing, are subject to removal. Excessive hypertrophy is occasionally seen in young adults and removal is advised, providing we can be reasonably sure that there is not some underlying disturbance which has caused the tonsil to enlarge as a consequence of combating or reacting with it. In the case of a simple hypertrophy of tonsil and adenoid to a point where the tissue is obstructive and produces the various well-known symptoms, the results of a properly done operation are always very gratifying to all concerned.

The good results following tonsillectomy in children, even as young as two years, having infected tonsils is well-known. In the presence of certain heart, kidney, joint diseases, and affections of the nervous system, the relief obtained by removing infected tonsils and adenoid in a child is such as to make the operation our duty. Various other well-known abnormal reactions, we have learned, are relieved by the removal of this source of infection and absorption.

However, in every series, there will occasionally appear a child in whom local and distant symptoms indicate the need of operation, but in whose case the careful surgeon will proceed with great caution. This statement does not refer to the child with serious heart, kidney, and joint lesions with which you are all familiar but to the highly allergic child. Our increasing knowledge of allergy only tends to impress upon us its serious possibilities in some cases. Some clinicians are convinced that status lymphaticus does not exist as an entity but is an allergic manifestation. Others do not agree with this conclusion and we ourselves do not know.

However, we do know that occasionally a terrific reaction, manifested by extreme temperature and great acceleration of pulse and respiration, does occur. This usually terminates in death in a few hours or in days of slow return to normal. Occasionally death is sudden; sometimes at the beginning of the anesthetic. In one case where we secured an autopsy, the thymus and spleen did not show significant changes but the lymphatics of the duodenum and mesenteric lymph nodes showed marked hyperplasia and congestion. The lungs were markedly congested and edematous without pneumonia.

Tonsillectomy in an adult suffering from a well-advanced constitutional disease is apt to be a disappointment to the patient and a reflection on the medical and surgical attendants. The questionable results of operation in such cases where "last resort" pharyngeal surgery is done should be explained to the patient and, if done, should include all infected lymphoid structures of the pharynx surgically accessible.

To those of us who have done many tonsillectomies and other more extensive surgical operations of the upper respiratory tract, the removal of the tonsil is not a minor operation. All angles being considered, the responsibility at the time of operation and for months or years afterward may not be a light one.

The protection against aspiration of secretion and *tissue fragments* and control of bleeding during the operation are very important. Bleeding points should be controlled by ligatures, No. 0, No. 00 or No. 000, plain catgut. Sutures on a needle should be used only in extreme instances where ligatures will not do.

In the removal of extensively infected tonsils or those with a very virulent type of infection, we have long felt that special care is important. Especially is this true in the presence of a systemic involvement which we feel has been due to the tonsillar infection. Such tonsils are not grasped with forceps at the start of the operation, but manipulated with a two-pronged hook for the dissection. We feel that any grasping of the tonsil can logically force into the lymph and blood stream toxic material in sufficient amount to produce a very noticeable immediate post-operative effect on the patient. By careful manipulation, such a "shower" of toxins can be reduced very greatly.

It seems hardly necessary to mention the im-

portance of preserving the integrity of the faucial pillars, the glossopharyngeal nerve in tonsillectomy, and the orifices of the eustachian tube and upper pharyngeal constrictor in adenoidectomy.

During swallowing and speech, the upper border of the superior pharyngeal constrictor in contraction forms, on the posterior wall of the pharynx, an elevation or pad which meets the soft palate and shuts off the naso-pharynx. Injury to this muscle produces the same symptoms, to a less degree, of a short soft palate and interferes with swallowing and speech. This injury occurs more often than is supposed and is done by misplacing the adenotome or by a too low and vigorous use of the curette.

My work in surgery of cleft palate has been a great aid in the other surgery of the oro- and naso-pharynx. Particularly so in secondary tonsillectomies and tonsillectomy in singers and others who use the voice extensively and at times forcibly, such as public speakers, auctioneers, and teachers. Good function of the structures of the pharynx must be retained, not only to prevent a speech defect but to prevent pharyngeal fatigue. Secondary tonsillectomy, where there are scars or actual loss of muscular tissue, always requires measures other than the ordinary to remove the remaining tonsillar tissue without increasing the existing defect.

In the majority of instances where one or more surgical attempts have been made to remove the tonsil and where electro-coagulation has been employed, it has been the experience of the writer that local anesthetic is unsatisfactory. Adhesions and scar tissue interfere with the proper diffusion of the fluid, thus preventing complete anesthesia in all areas. Furthermore, sharp surgical lines of demarcation may be partially obscured by the infiltrated surrounding structures even after a slight amount of fluid has been injected. Another point—and important—is that the patient's mental equilibrium is disturbed because of a necessary second or third operation and full cooperation cannot, in all instances, be secured.

With the patient under the influence of a general anesthetic, deliberate, careful, sharp dissection, with the palatoglossus and palatopharyngeous muscles retracted to afford constantly a good view of the position of the dissecting instrument, is essential to good work.

When properly used, the Davis mouth gag is admirably suited to this purpose as all, who are familiar with it, know. Further tissue contraction necessarily follows a subsequent operation, but, by careful work, this can be greatly reduced. The conservation of the palatal structures in secondary tonsil operations is highly important and frequently these structures suffer unnecessary injury due to the application of one routine of technique to which all tonsils are subjected.

Laryngologists called on to do tonsillectomy following electro-coagulation treatments have learned to anticipate difficulty in such an operation. Excessive bleeding, scars, often extending into the peritonsillar tissue, adhesions with the muscles, and extreme friability of the tissue are the principal difficulties to be dealt with. In this class of patients, ordinary methods of tonsillectomy may result in unnecessary contracture of the structures of the palate.

In cleft palate patients, the operation should be completed before the child begins to talk. Perfect or nearly perfect speech in these patients is always hoped for by the parents. Our aim, in addition to primary closure of the cleft, is to do this in a way to conserve the function of the muscles concerned in speech. Quite naturally this thought continues with us during tonsillectomy and adenoidectomy. A small defect in speech following a tonsil and adenoid operation in some patients means more than a more marked defect in another one.

A small child may sustain injury to the pillars, soft palate, uvula, eustachian tube, sense of taste, etc., and grow up with them, not complaining, but an adult patient will tell you promptly, especially if his speech or sense of taste be impaired.

The selection of patients with abnormal tonsils for constitutional treatment before or in lieu of surgery often involves a great responsibility on the part of the attending physician and usually calls for various kinds of consultants.

Adults with infected tonsils suffering with cardiovascular or renal disease, the various forms of arthritis, endocrine dysfunction, and lesions of the nervous system and many others, should not be advised as to treatment or surgery by the rhinologist without consultation with a competent medical man. As before mentioned, it is the question, "Will the operation at this time accentuate the constitutional disease?" or "Will the patient eventually be benefited?" These questions are often difficult to answer, and especially so in the presence of a tonsil showing infection and irritation in the surrounding structures. Fortunately for the rhinologist, the answer must come from the medical attendant.

TONSILLECTOMY RESULTS

Svent Heiberg (Copenhagen). (Acta Oto-Laryngologica, xix., fasc. 2.)

Three hundred and two patients who have undergone tonsillectomy have been examined afterwards by the aid of question forms, which in one hundred and ninety-seven instances were answered. Period of observation: three to ten years.

(1) Of one hundred and forty-six patients with relapsing acute tonsillitis, 81 per cent were free from symptoms after the operation and 15 per cent improved. The condition of some patients

was quite unchanged, despite a successful operation.

(2) Of sixty-five patients with peritonsillar abscesses, 94 per cent were cured, 4 per cent improved, and 2 per cent unchanged.

(3) Of twenty-three patients who prior to the operation had had from one to three attacks of rheumatic fever, one had had a relapse, whereas the others had been well.

(4) In ten patients with chronic rheumatoid polyarthritis, there had been an improvement in half the number, whereas half were unchanged.

(5) Eight out of ten patients in whose case heart trouble had been diagnosed (in most cases in conjunction with rheumatic fever), had not presented any heart symptoms after tonsillectomy.

(6) In twenty-three patients with indefinite throat and general symptoms, a satisfactory result had been recorded in only about half the number.

(7) A comparison between the presence of symptoms of pharyngitis and laryngitis before and after the operation indicated that operated patients are scarcely more liable to these attacks than non-operated patients.

(8) Thirty-one patients indicated a depreciation, eighteen an improvement of the singing voice after the operation, whereas ninety-nine stated that it was unchanged. When an operation is performed very conservatively, and systematic singing exercises are employed after the operation, it may certainly be expected that there will be no depreciation of the singing voice, even among singers, and that in some cases it may even be improved.

(9) Twenty-seven patients indicated swallowing troubles (tendency to get fluids "down the wrong way"). These cases do not seem to bear any relation to change in the voice.

(10) Out of two hundred and eighty-two patients operated upon there has been only one death, from post-operative hemorrhage and double pneumonia, in a patient with severe chronic nephritis.

(11) In 13 per cent of the operated patients there had been post-operative hemorrhage (5 per cent being slight and 8 per cent severe).

(12) After more than half of the operations there was a rise of temperature, which was only slight in the great majority of cases: in 4 per cent there had been more marked rises of temperature, usually accompanied by one or more serious complications in the form of pulmonary trouble, severe hemorrhage, or severe inflammation of the throat.

(13) In 2 per cent of the patients there had been marked, post-operative phlegmonous reaction in the throat; in all of these cases, the reactions disappeared in the course of some days.

(Author's Summary.) H. V. Forster.

Journal of Laryngology and Otology, 1934, 49: 421.

CONCLUSION

(1) In considering the importance of inflammations, with or without infection, or other abnormalities of the tonsil and adenoid, one should note the condition of the other lymphatics of the entire pharynx.

(2) The age and general condition of the patient must be carefully considered before advice is given.

(3) Unusual sub-acute or chronic enlargement of the palatine tonsil at any age indicates that more than the ordinary study of the patient should be made before proceeding with treatment.

(4) The present day trend of thought is that the tonsil has a definite function, at least during the first thirteen or fourteen years of life.

(5) When the function of any of the lymphatic follicles is surpassed by the effect of a pathological change, removal is usually advisable.

(6) While the various strains of streptococcus in the tonsil are the common offenders, this structure can be the source of the presence of the staphylococcus in the blood stream with its serious effects. When the pneumococcus is present with either or both, more serious results can be expected.

(7) Chronic streptococcic infection of the tonsil with toxin absorption and irritation in tuberculous patient may retard recovery.

(8) When eradication of the tonsil as a focus of infection has been decided, complete surgical removal, except in a few instances, should always be the treatment advised. No operator should, however, rely on only one technique for the removal of all tonsils nor, in some patients, the same for each tonsil. Neither should the internist without *good* reason advise a local or general anesthetic.

(9) Satisfaction to all concerned will be the outcome in well advised tonsillectomies. Disappointment in result and censure of the operation as a procedure, will follow in certain cases if a careful pre-operative study of the patient has not been made.

681 E. Broad Street.

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— OSMJ —

Cincinnati—The work of the Kettering Laboratory of Applied Physiology of the University of Cincinnati, College of Medicine, in seeking ways to combat occupational diseases, was discussed by Dr. Robert A. Kehoe at a recent meeting of the Men's Liberal Arts Alumni Association of the University of Cincinnati.

COMFORTABLE FEET FOR THE WORKER

By C. L. FERGUSON, M.D., Portsmouth, Ohio

HAS anyone ever said to you, "Doctor, my feet are simply killing me. What can you do for them?" Or he or she may express the same thought to a physician in industry and say, "I must have a different job because after eight or nine o'clock in the morning my feet hurt me so badly I am in misery all over. By night I am 'all in'."

When you are confronted with a double problem of recommending and finding a new job and devising ways and means of giving that worker relief, you realize for the first time, probably, the importance of his complaint.

Do we, as members of the medical profession, give patients with uncomfortable feet serious consideration? Do we examine the feet carefully, make a diagnosis and then prescribe a satisfactory treatment? It is my opinion that while such business rightly belongs within the realm of the medical profession, the doctors, as a whole, are either delegating or permitting such work to be done by people who know little or nothing about feet, shoes, or lasts. If advice is given, it is usually the casual remark, "Soak your feet every night in hot water, or get a pair of arch supports and wear them in your shoes."

Feet are made uncomfortable by a large number of different causes; but the scope of this paper is to include only those which can be relieved by shoes or the modification of shoes. It is not the intention of the writer to deal with operative, orthopedic, or some of the dermatological conditions, but with what he commonly calls foot disabilities.

I present, then, for consideration, pronation or what is otherwise known as weakness of the feet, inward rotation or acquired flat-feet; relaxation of a part or all of the anterior arch of the foot, bunions, corns, callouses, tailor bunions, Morton's toe, bursitis, ingrown nails, congenital shortening of the metatarsals, and spurs.

All of the above mentioned conditions can be relieved in part or in whole by the proper fitting and modification of shoes.

There are two other disabilities so common that they should be mentioned, though they are not effected or caused by foot wear. Neither are they improved by it, but they do complicate foot disabilities. They are verruca and "athlete's foot."

The writer considers himself fortunate in having been connected with a large shoe manufacturing company for the past 13 years, because he has had an excellent opportunity to observe foot symptoms complained of by anyone of its 3500 employees as they go about their daily routine of many different kinds of work. To supplement this experience, transients from all over the United States consult us about foot problems. Dealers, likewise, write in for information concerning customers who are attempting to get foot relief.

The relief of foot disabilities is comparatively simple after one fully undertsands the cause of the symptoms. During the past two years, much hocuspocus has been handed out by so-called foot specialists, some of whom never saw the outside of Gray's Anatomy. During the same time, shoe manufacturers became hysterical because they heard of a mysterious something, a magic touch, if you please, which was likely to revolutionize the entire shoe business and, incidentally, cure all foot troubles from corns to arthritis, if a certain type of shoe is worn.

While extensive foot propaganda was being distributed, the public became foot conscious and now hundreds of mushroom "foot specialists" have sprung up to take care of the feet of your wife, daughter, and patients.

Without removing the cause, such "specialists" are simply telling your patients how their feet should be jerked or twisted in order to be cured.

CAUSES OF FOOT DISABILITIES

Shoes, it can truly be said, are the cause of the majority of foot discomforts. Natives of countries where it is the custom to go barefooted have but little, if any, trouble with their feet. They can carry heavy loads on their shoulders or heads and subject their feet to tremendous strain with impunity. Likewise, the feet of millions of workers are subjected daily to a tremendous strain because of the weight imposed upon them while poorly balanced and crowded into shoes too short or too narrow.

It is estimated that the average person who is on his feet takes 19,500 steps daily. If he weighs 150 pounds, he will pound into his shoes about three million pounds per day. Take for example the individual who weighs 200 pounds, his or her feet are subjected to much more strain. Other causes of foot disabilities are occupation, illness, and a change in the style of lasts.

A woman missionary recently told me her experience in buying two pairs of shoes of the same size and the same make. One pair was absolutely comfortable, while the other produced untold misery even though riding on a pullman. This experience would seem hard to explain in view of the fact that she had two good feet. Measurement of the shoes showed one pair, the comfortable pair, to be ⅜ inch longer and ⅛ inch wider than the uncomfortable pair. A difference in the style

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of lasts was responsible for absolute comfort in one pair of shoes and agony in the other.

METHOD OF EXAMINATION

First, examine the shoes. These will, often times, tell as much as examination of the feet. Observe how the heels and soles are worn. Is the shoe twisted? Note the height of heel.

Then, have the patient remove stockings and examine feet for tender areas. Certain areas of tenderness indicate certain definite abnormal conditions. Make pressure, with the thumb, over the entire plantar area, over the sustentaculum tali, tibial ridge, and over joints of the foot and ankle. Test the motility of the joints for the degree of flexibility and tenderness. Next, have the patient stand on a glass top stand which is about 14 inches high. A slanting mirror under the glass top will reveal the degree of flatness or cavus. It will also reveal areas carrying excessive weight associated with callous.

While on the stand, it is wise to check for rotation of the foot. This can be determined by suspending a plumb line from the center of each patella to the dorsum of the foot. Normally, the plumb bob should point to a spot in the region of the second metatarsal. If it points to the third or fourth metatarsal, a pronation exists, providing the legs are straight.

Tenderness over a joint indicates, as a rule, the presence of arthritis. If such is suspected, it is then necessary to make a complete physical examination to determine, if possible, the cause. What, then, do we find by such examination? If tenderness is found over the sustentaculum tali, spring ligament, and tibial ridge, and if your plumb line points to a spot outward from the second metatarsal, and if the shoes show wear on the inside, we can make a diagnosis of pronation. It is the writer's belief that pronation is the major cause of most of the very disagreeable foot symptoms. If a callous is found under the distal heads of the metatarsals, we say there is a relaxation of the anterior arch.

Tenderness under the heel associated with the patient's subjective symptoms and a radiograph showing a calcarious formation extending from the oscalcis in line with the plantar ligament justify us in making a diagnosis of a spur.

A bunion needs no describing because its appearance is familiar to every one. A tailor's bunion is a similar condition existing in the first joint of the little toe.

Subjective symptoms and tenderness along the fourth metatarsal with a history of pain extending to the end of the fourth toe are sufficient to warrant making a diagnosis of Morton's toe.

Bursitis, a very common condition, is most frequently found over the lower end of the tendon Achilles. It is characterized by tenderness and swelling over this area.

OTHER SYMPTOMS ARISING FROM FOOT DISABILITIES

Uncomfortable feet presenting the various conditions just mentioned cause symptoms elsewhere. Pain in the feet is referred to the calves of the legs, knees, thighs, and backs. These symptoms located elsewhere are often diagnosed as rheumatism, arthritis of the knees, sciatica, sacro-iliac sprain, and lumbago.

It is extremely interesting to observe, in many instances, the disappearance of such symptoms by relieving uncomfortable feet.

INDUSTRY'S CONTRIBUTION

For the past two or three decades, modern industry has, through its medical departments and hospitals, endeavored to do much to diminish morbidity by annual and semi-annual examinations. Foci of infection have been sought in the usual locations and eliminated where possible. The elimination of such foci has meant more comfort for the worker and less lost time.

Modern industry has installed up-to-date heating, lighting, and ventilating systems, thus providing a deserving comfort for the worker. In spite of all that has been done, industry can go a step farther and provide relief for foot disabilities which are interfering with the worker's comfort and his earning capacity. It is estimated that from 80 per cent to 85 per cent of the population have some sort of foot disability.

Such disability is just as distracting and interferes with one's ability to concentrate and produce as does any other kind of pain elsewhere in the body.

TREATMENT

How, then, can relief be offered such patients? The treatment of foot disabilities is comparatively simple. Some equipment, of course, is necessary. This includes a standard foot measuring device, an ample assortment of the various sizes of shoes that come within a sensible classification, a person who understands the fitting of shoes, metatarsal pads of different sizes, piano felt, cutting block, sharp knife, scissors, leather, kid skins, channel cement and a brush. An *X*-ray is invaluable and should be included.

It is the writer's experience that, excluding arthritis cases, foot relief can be secured either immediately or within a comparatively short time. Some of the most severe cases report complete relief in three to four weeks.

Pronation can be relieved by properly balancing the foot in a shoe of proper size. I mean a shoe which is of the proper length and with sufficient toe room. Both feet should always be measured to assure the patient of proper fit because one foot is frequently found to be a size longer and wider than the other. Always fit the larger foot. If a wide variation exists, then shoes of different sizes will give the greatest degree of comfort. Personally, I prefer a rigid shank shoe because

pronation cases require sturdy support for a foundation. If the worn shoes of such patients are examined, especially if the shoes are inexpensive and flimsy, they will be found to be twisted entirely out of shape. In the rigid shank shoe a piece of skivel leather, 3¼ inches long and 9/8 inch wide for men, and a smaller size for women, is cemented along the inner side of the shoe and on top of the inner-sole. An oval flare extends over the inner quarter ⅝ of an inch and provides support under the longitudinal arch. Sometimes, it is necessary to place a piece of felt on top of this piece of leather in order to balance the foot properly.

If a flexible shank shoe is used to relieve pronation, a new heel should be built with the inside of the heel extending forward about 3/4 inch. Such a heel is known as a Thomas heel. This type of heel provides the necessary support under the scaphoid bone and it also tends to prevent the os calcis from rotating inward. Heels should never be over 12/8 inch high. An 8/8 inch heel is better. However, cases which have a marked contraction of the tendo Achilles should be let down gradually or advised to wear low heel shoes for a short time only each day until the tendon becomes sufficiently stretched. In marked cases of pronation, the function of the Thomas heel can be supplemented by making the inner side of the sole and heel 1/8 inch thicker.

The symptoms of a relaxation of the anterior arch can be relieved almost instantly by using a sensible shoe in which is placed a metatarsal pad. Each individual rendering relief prefers his own kind of pad. Personally, I prefer one of sponge rubber which is about the size of a dollar.

The success of these metatarsal pads depends upon the proper placement in the shoes. They should not be placed under the distal heads of the metatarsals, but should be placed just back of them to maintain a normal relation of the metatarsals and at the same time to feel comfortable. I like to place these pads myself in order to assure comfort. Sometimes, I have to take the pad out five or six times and replace it in order to get it properly located. Very often the placement of it forward, backward, or to either side 1/16 of an inch is sufficient to make the patient say, "Now that is comfortable."

Morton's toe requires a properly fitted shoe with emphasis on the width. In addition a metatarsal pad is necessary. Bunions, whether of the big or little toe, first need shoes built over a straight last in order to permit the toes to spread so as to relieve pressure. Corns and callouses will be relieved, or they may go away entirely, if shoes of proper size are worn. Corn cures are not necessary. Callouses under the anterior arch are greatly helped by low heel shoes with metatarsal pads.

Since spurs are caused by a chronic irritation due to foot strain, it is only necessary in most instances to relieve this strain by a low heel shoe, properly balanced to take the strain off the plantar ligament.

Bursitis over the Achilles tendon can be cured by removing the shoe pressure at this point. Felt and cement are useful agents here. A small piece of felt 2 inches long and 1 inch wide—⅛ inch to ¼ inch thick on one edge tapered to nothing at the other is cemented in the back of the heel of the shoe. This piece of felt keeps the foot far enough forward so that the pressure is removed from the heel, and thus provides immediate relief. Here again a better fitting shoe is necessary.

The congenital shortening of one or more of the metatarsals is rare; but when it does occur, such deformity interferes with the normal function of the foot.

A simple remedy which will often give complete relief is to place a long slender piece of felt about ⅛ inch thick and ¾ inch wide under the short metatarsal and allow it to extend under the distal head and under the proximal half of the toe.

SUMMARY

In conclusion, I wish to reiterate that it is unnecessary for persons with foot disabilities to suffer physical and mental agony; that the correction is simple; that the physician should know the fundamental principles of shoe and last making; and that, in most cases, a properly fitted shoe or a modification of the shoe will relieve the foot disability and symptoms incorrectly diagnosed.

DISCUSSION

P. A. DAVIS, M.D., F.A.P.H.A., Akron: I want to commend Dr. Ferguson on this paper. It gave me a great amount of pleasure and satisfaction to read the copy he sent to me, for I could appreciate the problems he has attempted to solve. When we make our debut into this world, if our progenitors have not broken the good laws of nature we are supposed to have two good feet with four principal arches.

From this time on it is a battle of the arches against environment and disease. Hundreds of years ago the aborigines won and preserved their arches and had very little foot trouble. Today with our ultra-modern civilization the arches are slowly being levelled. The attacking forces which are securely entrenched at the present time are the following:

1. Man-made devices which inhibit the normal functions of the arches.
2. Solidification of the battle ground by cement, marble, hard wood, and importations from the black hole of Trinidad.
3. The counter attacks of our microscopic enemies, especially Major Staph and Captain Strepto.
4. The constant but ever present forces directed by gravity attacking us from the air.
5. The iron masked God Auto who has gastrocnemius and femoris in his grip and refuses to give them a leave of absence.
6. Counter forces which have blockaded A, B, C, and D supplies.

In 1919-20, I examined one division of the army

of this war of Arches consisting of 2014 men and found that 16.5 per cent had received disabilities to some degree to their internal anterior posterior arches.

What are we to do with our casualties and how are we going to win this war? You have just heard a very excellent proposal by one member of the staff but victory cannot be accomplished single handed. My proposal is to limit and restrict or annihilate enemies one to five inclusive and remove the blockade from six so that supplies are available. Casualties should be treated according to their diagnosis, that is, whether it is infectious, due to mechanical injury or to defect in nourishment.

I am somewhat skeptical about the use of arch supports or foot splints over a long period of time for they soon become part of the individual. I believe that reconstruction exercises, removal of the cause or causes and a regulation of the individual's activity will produce more beneficial and lasting results. I have seen 3rd degree flat foot completely corrected over a period of time by such procedures.

Seriously, we have not given much thought to these conditions and I do not know how much time and money is lost to the individual, but it must be enormous. We should give this some thought, especially those connected with industry and the supervision of the growing child. Again I recommend the perusal of the manuscript by Dr. Ferguson.

—OSMJ—

New Books

Economic Problems of Medicine by A. C. Christie, M.S., M.D., Professor of Clinical Radiology, Georgetown University Medical School; formerly president of the Medical Society of the District of Columbia; member of the Committee on the Costs of Medical Care and chairman of a Sub-Committee on Information of the Committee on Medical Economics appointed by the Medical Society of the District of Columbia. The subjects discussed are medical ethics in its relation to medical economics; economic aspects of medical education; economic aspects of private practice; the physician and the hospital; the relation of the physician to medical organization; the relation of the physician to the community; medical care under workmen's compensation laws; health insurance; industrial medicine; new methods of medical care under trial or recommended by medical organizations; health insurance as a solution to the problems of medical care; essential elements in a comprehensive plan for medical care. The MacMillan Company, 60 Fifth Avenue, New York City, publishers; price $2.00.

—OSMJ—

The fifth annual series of addresses under the auspices of the Benjamin Knox Rachford Lectureship, University of Cincinnati, was given by Dr. Roy Graham Hoskins, director of the Memorial Foundation for Neuro-endocrine Research, Harvard University, Boston.

Ohio Death Rate Increases For First Time in Past Five Years

A summary of the provisional figures in Ohio of the mortality compilation for 1934 shows a marked increase over the complete data for 1933, according to the Bureau of Vital Statistics, State Department of Health. The death rate for last year was 10.9 per 1000 population as compared with 10.5 for 1933, which was Ohio's lowest death rate since the establishment of registration.

The increase of 3,610 deaths during the year was the first mortality increase recorded since 1929, at the beginning of the depression.

An analysis of the data shows an increase of 10 deaths each day during last year. There were 46 deaths each day from diseases of the heart, an increase of two per day; 22 from cancer (all forms), an increase of one each day; 21 from cerebral hemorrhage, an increase of one each day; 18 from accidents (all forms), an increase of two per day; and 14 deaths from pneumonia, an increase of three per day over the figures for 1933.

Many causes of death continue to show decreases, namely, typhoid fever, influenza, tuberculosis (all forms), diseases of the nervous system, diarrhea and enteritis under two years of age, the puerperal state, diseases peculiar to early infancy, suicides and homicides.

Tabulated below are the principal causes of death, with rates per 100,000 population for the years 1933 and 1934:

	1933 No.	1934 No.	1933 Rate	1934 Rate
Typhoid fever	120	116	1.76	1.65
Smallpox				
Measles	118	145	1.70	2.06
Scarlet fever	218	224	3.14	3.19
Whooping cough	152	301	2.19	4.29
Diphtheria	174	197	2.50	2.80
Influenza	1,554	1,184	22.36	16.87
Acute anterior poliomyelitis	52	37	.75	.53
Lethargic encephalitis	69	71	.99	1.01
Epidemic cerebrospinal meningitis	32	59	.46	.84
Rabies	2	1	.03	.01
Tuberculosis (all forms)	3,640	3,487	52.45	49.69
Cancer (all forms)	7,618	7,915	109.78	112.79
Diabetes	1,575	1,660	22.70	23.65
Diseases of nervous system	8,643	9,065	124.54	129.18
Cerebral hemorrhage	7,021	7,651	101.17	109.03
Diseases of circulatory system	18,252	18,894	263.01	269.24
Diseases of the heart	16,221	16,881	233.74	240.55
Diseases of the respiratory system	4,742	5,951	68.33	84.81
Pneumonia (all forms)	4,109	5,180	59.21	73.82
Diseases of the digestive system	4,592	4,555	66.17	64.91
Diarrhea and enteritis (under 2 years)	548	517	7.90	7.37
Diseases of genito-urinary system	6,203	6,598	89.38	94.02
Nephritis	5,233	5,459	75.40	77.79
The puerperal state	579	556	8.34	7.92
Malformations and diseases peculiar to early infancy	3,175	3,131	45.75	44.62
Suicide	1,242	1,101	17.90	15.69
Homicide	553	495	7.96	7.05
Conflagration	102	78	1.47	1.11
Accidental burns (conflagration excepted)	318	248	4.58	3.53
Accidental falls	1,583	1,433	22.81	20.42
Railroad accidents	417	299	6.01	4.26
Streetcar accidents	83	61	1.20	.87
Automobile accidents	1,843	1,965	25.89	28.00
All other accidents	1,571	2,390	22.64	34.06
Total accidents	5,917	6,473	82.26	92.24
All other causes	3,830	4,449	55.19	63.43
Grand Totals	73,052	76,662	1,052.67	1,092.43

PUBLIC HEALTH--SOCIAL WELFARE--MEDICAL ECONOMICS *and* ORGANIZATION PROBLEMS

Annual Meeting Program Nearly Completed; Local Committees Hard at Work

Preliminary arrangements for the 89th Annual Meeting of the Ohio State Medical Association, Wednesday, Thursday and Friday, October 2, 3 and 4, at the Netherland Plaza, Cincinnati, are rapidly being completed.

Under the direction of the Council Program Committee, consisting of Dr. Parke G. Smith, Cincinnati, chairman, Dr. C. L. Cummer, Cleveland, and Dr. R. R. Hendershott, Tiffin, the program for the Cincinnati meeting is in the process of being completed and promises to be one of the finest ever arranged for an annual session of the State Association.

Aside from the splendid scientific section programs that have been formulated, there will be several general sessions of great merit and of interest to both general practitioners and specialists.

Four prominent physicians from outside Ohio and two well-known Ohio physicians will address the general sessions. They are: Dr. James B. Herrick, Chicago; Dr. Frank H. Lahey, Boston; Dr. Palmer Findley, Omaha; Dr. Morris Fishbein, Chicago; Dr. R. Wesley Scott, Cleveland; and Dr. L. L. Bigelow, Columbus.

One of the features of the program to be presented at the annual banquet on Thursday evening, October 3, will be a short address by Dr. Jonathan Forman, Columbus, describing the highlights of the medical convention held in Columbus in 1835, the first held in what was then the young State of Ohio.

An unusually large number of physicians have arranged to present scientific exhibits and this part of the program will be one of the chief attractions of the meeting.

The complete program for the meeting will be published in the September 1 issue of *The Journal*. In the meantime, every member of the State Association should begin arranging his business affairs so that he can be in Cincinnati for this unusual opportunity to enhance his knowledge of scientific medicine and join with the essayists and discussants in discussion of practical solutions of many medical problems.

Committees of the Cincinnati Academy of Medicine in charge of local arrangements are hard at work completing plans for entertaining the visiting physicians and handling the many details incidental to the meeting.

Working under the guidance of Dr. Edward D. King, president of the Cincinnati Academy, and Dr. Parke G. Smith, general chairman of the Committee on Arrangements, these committees are as follows:

Reception—Edward D. King, chairman, R. S. Austin, M. A. Blankenhorn, Robert Carothers, Robert B. Cofield, Frank M. Coppock, Jr., Mr. Clarence Dykstra, Howard F. Fischbach, Albert H. Freiberg, Alfred Friedlander, Rufus B. Hall, Chas. D. Heisel, Samuel Iglauer, Clarence King, Sidney Lange, Charles J. McDevitt, Gordon F. McKim, A. Graeme Mitchell, E. A. North, F. D. Phinney, Mont R. Reid, F. M. Solar, Chas. T. Souther, Elmore B. Tauber, Raymond Walters, Hon. Russell Wilson, Henry L. Woodward.

Banquet—Louis Feid, Jr., chairman, Frank E. Cunningham, Hugh H. Hengstenberg, Daniel C. Rivers, Emil R. Swepston.

Clinics—Dudley Palmer, chairman, Lloyd B. Johnston, associate chairman, J. F. Bateman, B. N. Carter, Stanley E. Dorst, Joseph Ganim, Ralph W. Good, Howard L. Schriver, E. B. Shewman, Chas. T. Souther, Frank E. Stevenson, David A. Tucker, Jr.

Commercial Exhibits—Otto Seibert, chairman, B. E. Boyer, H. Jerry Lavender, Emil R. Swepston, H. H. Vail.

Entertainment—Henry B. Freiberg, chairman, C. E. Hauser, V. B. Roberts, H. H. Vail, Sam Zielonka.

Halls and Meeting Places—Horace F. Tangeman, chairman, D. J. Bradley, Thad. Gillespie, E. A. Kindel, Davis Lillard, Samuel Seltz, Emil Swepston.

Projection Apparatus—Wm. Miller, chairman, Gene Stevenson.

Publicity—Carl A. Wilzbach, chairman, J. W. McCammon, Robert Rothenberg, Jerome Zeigler.

Scientific Exhibits—Symmes Oliver, general chairman, Alfred Friedlander, chairman Medical College Group, Oscar Berghausen, Joseph Ganim, Geo. Guest, Robert Kehoe, K. V. Kitsmiller, Cecil Striker.

Women Physicians' Entertainment — Helena Ratterman, chairman, Marion Abbott-Boyd, S. Bertha Dauch, Vera Norton.

Those planning to attend the Cincinnati meeting are urged to secure their hotel reservations immediately. Cincinnati is a convention city and, although it is well supplied with hotel facilities, rooms are usually at a premium. Therefore, in order to obtain quarters convenient to the meeting place, reservations should be obtained

promptly. A list of Cincinnati hotels, together with their rates and conveniences, was published in the June issue of *The Journal*, page 458.

— OSMJ —

The NRA Decision and Pending Social Security Legislation

Many physicians doubtless are wondering what effect the recent decisions of the United States Supreme Court in the NRA and railroad pensions cases will have on legislation recently enacted by Congress to establish various forms of social insurance, originating from the report of the President's Commission on Economic Security.

Others are asking the same question.

To date, no very lucid answers have been forthcoming.

Interesting comment on this subject was published in an issue of *The United States News* shortly after the history-making Supreme Court Decision on the NRA cases and was in part as follows:

* * *

WELFARE, like many another national problem, toppled from its headline position in the country's press on the day the Supreme Court handed down its history-making decision. Then, a few days later, it came startlingly to the fore as a result of the unexpected turn given by the President at his press conference.

Of late, certain well defined trends in the welfare scene, tied together, have given evidence of important developments to come in the drift from economic and social hazards to a more systematic assistance on the part of the Government against insecurity.

If, as the President pointed out, control of national social problems was to be denied to the Federal Government, what is the fate of the omnibus social security bill, which sought to empower the Congress to carry out its constitutional duty of promoting the general welfare of the citizens of the United States?

SPONSORS of the social security bill point out that under Article I, Section 8, Clause 1, of the Federal Constitution, "The Congress shall have the power to lay and collect taxes, duties, imposts and excises, to pay the debts and provide for the common defense and the general welfare of the United States."

However, as the United States Law Week points out, the Supreme Court has never ruled on the power of Congress "to expend public money for any purpose considered to be in the general welfare without restriction to the remaining enumerated powers of Congress set out in the Constitution."

Government counsel, in a case now awaiting a decision by the Circuit Court of Appeals, involving a condemnation of land for slum clearance and low-cost housing construction, argued that "Congress may, as a complement to its power to levy taxes for the general welfare, appropriate and expend money raised by taxation in such manner as it thinks will best benefit the general welfare."

The Government counsel further added that "the general welfare clause was understood and intended to confer a broad, unrestricted power of taxation and appropriation for the general welfare."

THE question apparently boils down to one of the definition of "general welfare."

Counsel for landowners in the land condemnation suit argued that when the Constitution speaks of general welfare it means "the general welfare of the whole United States. Taxes are to be levied and appropriations made, not for the benefit of individuals, but for the entity known as the United States."

Speaking over a nation-wide radio network last week, Senator Pat Harrison (Dem.), of Mississippi, chairman of the Senate Finance Committee, said that it is the opinion of the experts in the Department of Justice who have studied the provisions of the social security proposal "that they are not affected by the Supreme Court's decision of last Monday, or the railroad retirement pension decision of some weeks ago."

THIS statement, however, was made before the President tinged the outlook for Federal social proposals with shadows. To add to the confusion, Edwin E. Witte, Executive Director of the President's Committee on Economic Security, has gone on record in the current issue of "State Government" as saying that despite the New Deal legislation, there is grave doubt "whether the Federal Government has authority to establish a national system of unemployment compensation."

Mr. Witte points out that there is no constitutional basis for such action except the taxing power and the welfare clause of the Constitution. The latter, he declares, "has never been regarded by the Supreme Court as conferring any powers on the Congress not granted specifically, and the former, while broad, cannot be employed where the court deems the tax a mere subterfuge for unauthorized regulation."

Even before the Supreme Court's decision, Mr. Witte realized the hazards of setting up a federally administered unemployment insurance system. The only safe course, he said, was one administered by the states.

However, the social security bill provides for a cooperative State-Federal plan. It imposes uniformity where uniformity is necessary and in all other matters allows wide latitude to the states to enact the kind of systems which will meet their local problems.

But will this division of powers between the

States and the Federal Government in the matter of social security be sustained in the event of a court test? At present, the social security issues are as clouded as many another national problem following in the wake of the Supreme Court's decision.

—OSMJ—

On the last page of *The Journal* is published each month a list of the standing and special committees of the State Association.

Have You Been Doing Your Part in State Association Activities?

These committees have important responsibilities. Through them, many of the activities of the State Association are successfully carried on. Their work is of major importance in the program of organized medicine in Ohio. They deserve the assistance and cooperation of all members in their undertakings.

Have you ever offered these committees suggestions as to new activities they might add to their present ones?

Have you ever volunteered your active participation in the work they are doing?

Have you ever sent them information that might be incorporated in their reports to the Council and the House of Delegates?

Think it over. Have you been giving these representatives of yours the support and assistance they deserve?

The committees of the State Association welcome suggestions and criticisms from the membership generally.

They are now preparing their reports for submission to the House of Delegates at the next Annual Meeting in Cincinnati, October 2, 3 and 4.

Why not communicate with the chairmen of these groups and furnish them with helpful and pertinent information that can be considered in connection with these reports?

Participation by all members in all activities of the State Association, including the work of its committees, is essential. It will enhance the influence of medical organization and make the State Association a more progressive and stronger vehicle for serving the best interests of the profession generally.

Incidentally, what do you think of *The Ohio State Medical Journal?*

Have you any constructive criticism as to its content, make-up, etc.?

Efforts are being made constantly to improve *The Journal* and increase its value to the membership.

Send us your comments. It's your *Journal.* You can, if you will, help to make it a better publication.

Osteopathic Prexy Suggests $15,000 Legislative Pot

"If we ever succeed in placing a law upon the statute books of Ohio that will give us the rightful standing according to the law of the state; if we ever hope to control our own professional conduct to the general public, we must register every member practicing within the state, raise a fund of at least $15,000, and submit the bill that will serve our purpose by creating an independent Board of Osteopathic Physicians and Surgeons."

The above is quoted from a communication signed by the president of the Ohio Society of Osteopathic Physicians and Surgeons and published in a recent issue of *The Buckeye Osteopath,* with reference to the defeat in the 91st General Assembly of a proposal that would have legislated osteopaths into the practice of medicine on an unlimited basis, despite their inferior educational qualifications.

To quote from the Buckeye's editorial column, dripping with sympathy for those who have failed to take advantage of the great benefits osteopathy offers:

"Everything seems to point to an increased activity on the part of the allopathic fraternity in its never-ending denunciation of all things osteopathic.

"In a way, this is a good sign. It shows that organized allopathy is not asleep to the serious inroads that osteopathy is making into the clientele which the prescription writers have always considered as their own personal property. Their hundred million guinea pigs are persistently becoming osteopathy conscious, and the self-styled guardians of the public health at times wax exceedingly angry.

"In bringing Dr. Etherington down from Canada to look over the osteopathic educational facilities in America, the allopathic fraternity played its trump card. Etherington made just the report he was expected to make, but he overstepped the bounds of decent fairness to such an extent, and his report was obviously so untruthful that the newspapers of the land refused to give it space. The trump card proved to be only a joker. The English, whether residents of England or of Canada, are inclined to be somewhat 'sot in their ways,' and are notoriously slow to accept improvements in everything from bathtubs to osteopathy. And it is not strange that along with the Etherington mis-report we find that the English house of lords is still so politically manhandled that it has recently turned down the osteopathic request for legal recognition.

"The director of the surgical unit at St. Bartholomew's Hospital in London said: *I have never been able to find anything which could be called an osteopathic lesion, though since I have been called to the inquiry I have gone back to the wards and looked for it.*

"The director's search for the osteopathic lesion might be likened to the writer's search for music in a flute—we know there's no music there because we couldn't produce it.

"Although millions of intelligent people have osteopathy to thank for their lives and their

healed bodies, and although these millions have looked in wonderment at the control of healing forces under the ministrations of osteopathic hands, yet the Britishers say: *It was the absence of any scientific basis for the osteopathic theory that proved fatal (to the bill).*

"It is true that osteopathy has been slow in bringing forward its scientific proof—shamefully slow, but with its practical proof it shakes allopathic medicine to its foundations. The Truth is there, and it is only man's ignorance and man's greediness that keeps it hidden from the world. It makes little difference what the high-brows of science have to say of the osteopathic theory just so long as osteopathy brings improved health to diseased humanity."

—OSMJ—

Proof of the Pudding Depends on Whether Or Not You Eat

"But the Operation was Successful", an article written by an anonymous physician and published in a recent issue of *The Saturday Evening Post*, strikes us as being apropos in these days when contentment is at a premium.

The author, the son of a country physician, aspired to be a big-city surgeon. He achieved his ambition during the balmy days of 1923-1929. He stepped along in a high, wide and handsome manner, with the sky the limit. Like many others in those days, he kept up with the parade with little, if any, thought of the future.

Then came the crash. The cost of maintaining his elaborate office and prominent social position, the stock market debacle, and a drastic curtailment in his earnings from practice, left him in a precarious position in 1934.

What he did may point the way out for others who find themselves in the same predicament and should serve as a lesson to those about to begin practice.

The concluding paragraphs of his story merit careful consideration:

"I tried to find some other way out. There was none. Every symptom I saw indicated that either the insurance companies or some form of state medicine would take over private practice. State medicine, in the end, seemed sure to win out. One of the most successful medical men in the United States in his day, now in retirement at sixty-seven, told me:

" 'State medicine would really be a good thing if it didn't go too far. I've always thought it unfair to soak the rich in order to care for the patients who can pay a little, but won't pay anything. If a scale of fees enforced by the Government could be established, with private practitioners working under a code, but still permitted to take care of their own group of patients, that might be a beneficial form of state medicine.

" 'But the tragedy is that it will go much farther than that. The tragedy is the patients' tragedy. Very soon, under state medicine, patients and doctors would be classified by the numbers or geographical zones, and the patients would not be able to choose their doctors. Specific doctors would be assigned to specific patients by some sort of medical administration.

" 'That would be a tragedy, because there is no substitute for a patient's confidence in his doctor, nor any substitute for a doctor's intimate knowledge of his patient's physical and mental background, and so forth, in my opinion. That is why I, for one, never believed in the superspecialization we developed in private practice.'

"About the time the old medical man made this prediction I found that I, personally, had to do something about me, financial patient, and do it quickly. I was borrowing to pay the rent on my offices. I was on my financial deathbed. What desperate remedy could I prescribe?

"I could buck the tide, wait and struggle, go into debt, give ground gradually and grudgingly, skimp and scratch at home, meanwhile keeping up as serene and prosperous a front as I could. I could, by so doing, take care of my old patients, but in the end they would lose along with me, if the prophecy of the retired medical man were correct.

"Inevitably, my thoughts drifted backward through my career. I began thinking of the town of my birth. Of the trout streams in the hills, of warm, bubbling milk in pails, of crocks of new-made butter in the spring house, of deep feather beds.

"I added up my assets. I could expect a total of $22,000 or more from the sale—even if forced—of our house, our big car, our pictures, pretentious furniture and other trappings. That would be more than enough to see the girls through school. For some $5000 I could buy a home in my town, ample surrounding acreage, and a small car. For $1500 a year I could live there in greater comfort than in the city on my dwindling earnings.

"There would be plenty of work; there wasn't a first-rate surgeon within fifty miles of my home town. What if I did occasionally get a ham instead of a ten-dollar bill as my fee? A ham would be a great deal more filling than promises of 'I'll pay you when I can.' And our daughters, at or approaching a marriageable age, would not be cut off from their old friends by our retreat to some shabby apartment in the city and the lack of funds to entertain. Their friends could week-end on our place. In our own community, my daughters would be of the elect.

"So I passed away as a 'brilliant' big-city surgeon. I came home. I found myself not defeated but triumphant. Here at home the friends of my boyhood consider me a man who won. My spirits are as high as ever they were in 1929. I have found the kind of new self-respect that I first experienced during the World War.

"What of the future? I have nothing to fear from the future, because I am a young man in a new world, and I do not think of the future at all, being too young for such thoughts."

CHANGES IN FERA MEDICAL PLAN, WORKMEN'S COMPENSATION PROBLEMS, LEGISLATIVE ACTIVITIES, ANNUAL MEETING DETAILS CONSIDERED AT JUNE MEETING OF COUNCIL

MINUTES

THE Council of the Ohio State Medical Association met in regular session in the headquarters office, Hartman Theatre Building, Columbus, Sunday, June 2, 1935.

Those present were: President, Dr. Caldwell; President-elect, Dr. Hendershott; Treasurer, Dr. Beer; Councilors, Drs. Huston, Klotz, Hein, Jenkins, Davidson, Kirkland, Brush and Seiler; Dr. Upham, chairman, Drs. Houser, Platter and Stone, members, Policy Committee; Dr. Bigelow, chairman, Committee on Medical Economics; Executive Secretary Nelson, and Assistant Executive Secretary Saville.

The minutes of the special meeting of the Council held on Sunday, April 14, 1935 (pages 363 to 366, inclusive, of the May, 1935, issue of *The Journal*) were read, and there being no corrections or additions, were ordered *approved* as published.

RESUME OF REVISED MEDICAL RELIEF PLAN APPROVED BY FERA ADMINISTRATOR STILLMAN, REPORT OF POLICY COMMITTEE ON NEGOTIATIONS AND ACTION OF COUNCIL

Dr. Upham, chairman of the Policy Committee, submitted the following statement regarding negotiations with State Relief Administrator C. C. Stillman and summarizing important changes in the medical relief program authorized on May 28 by Mr. Stillman. (A detailed account of the modified medical relief program, which will be placed in operation July 1, will be found elsewhere in this issue of *The Journal*):

Statement to the Council

The members of the Council are familiar with the negotiations which have been carried on by the Policy Committee with the State Relief Administration in an effort to secure changes in the Rules and Regulations governing medical care of those on relief. As the Council knows, the Policy Committee on April 13, 1935, held a conference with Relief Administrator Stillman, at which all angles of the medical relief program were discussed and the views of the medical profession forcefully presented. It was admitted at that time by Mr. Stillman and the members of his executive staff that certain changes in the medical relief program were necessary in order to meet serious difficulties which had arisen in a considerable number of counties, notably the drastic pro-rating of fee bills submitted by physicians for the care of relief patients.

At the suggestion of Mr. Stillman, who manifested a sincere desire to bring about improvements in the medical program, the Policy Committee undertook the responsibility of assembling pertinent information from the various counties of the state and formulating a revised set of Rules and Regulations.

After several weeks of intensive work, during which time data were secured from approximately 75 county medical societies and the headquarters offices of six or eight medical associations in neighboring states, the Policy Committee, on May 15, held another conference with Mr. Stillman and submitted to him a revised set of Rules and Regulations based, for the most part, on the information which had been obtained through correspondence and otherwise.

The suggested modifications and additions to the medical program Rules and Regulations presented to Mr. Stillman were summarized in detail in the June 1 issue of *The Journal*, pages 453 to 457, inclusive.

On May 25 Mr. Stillman notified the state headquarters office by telephone that the recommendations of the Policy Committee had been thoroughly considered by him and his assistants and that he had authorized incorporation of a number of the recommendations of the committee in the Rules and Regulations governing the medical program. At the same time, he stated that for reasons beyond his control, which he would explain in an official communication to the Ohio State Medical Association, he had found it impossible to accept some of the recommendations which had been offered by the Policy Committee.

Under date of May 28, Mr. Stillman wrote the Executive Secretary, outlining his decision on certain changes that would be made as soon as practical in the medical relief program.

The revised plan, as summarized briefly in that communication, is as follows:

1. **The available amount of money for medical care in any county will be the sum obtained by multiplying $1.00 by the number of current family relief cases, plus an amount represented by multiplying 25¢ by the number of single cases exclusive of transients. (Under the former plan, no amount was made available for medical care of singles).**
2. **The amount representing the cost of medical supplies will be considered apart from the amount available for medical services. (Heretofore, the cost of medical supplies has been met out of funds made available through the $1.00 per family allocation and paid, in most instances, at 100¢ on the dollar before bills for professional services were paid. This was responsible for pro-rating of physicians' bills in many instances).**
3. **No changes will be made in the fee schedule and pro-rating will be resorted to when necessary.**
4. **An effort will be made by the State Relief Administration to have each county relief director set up on a voluntary basis an advisory committee composed of a physician, a dentist, a nurse, a pharmacist and the relief director or his proxy. In formulating such a committee, the local relief director will be expected to secure the cooperation and assistance of the county medical society and societies representing the local dental, nursing and pharmaceutical professions. In this connection, it is planned to have the physician member of the advisory committee serve as a medical adviser to the local re-**

lief administration and assist in validating bills for professional services, supplies, etc. The idea was offered that should the physician medical adviser choose to give a designated number of hours, up to three or four a day, for field service in connection with the medical relief program, then he would be placed on a salary basis at an amount to be agreed upon by him and the local relief director.

Mr. Stillman pointed out that he had hoped to place the new plan into operation during the month of June, but he had found that budget procedure had reached the stage whereby he was precluded from applying the plan to that month. However, he stated that they would endeavor to be as liberal as possible in the allocation of funds for June and that the new program would be taken into consideration when budgets for the month of July are approved.

Mr. Stillman said that the work of revising the Rules and Regulations in accordance with the foregoing authorizations would be assigned to certain members of his executive staff and that he had instructed them to invite representatives of the Ohio State Medical Association to assist and cooperate with them in formulating the regulations for the revised medical program.

In pointing out why he had been unable to accept one of the important recommendations of the Policy Committee, i.e., the establishment of a central pool of the funds for medical care from which allocations could be made to individual counties on the basis of actual need, Mr. Stillman stated,

"It is not permissible to allow any unused money for any month in any one county to be held over for application to the medical costs in such county in a succeeding month or to transfer any unused balances in any county for use in other counties in the same or succeeding months."

In a previous conversation, Mr. Stillman had pointed out that rigid accounting regulations have been established by the federal government which prohibited the maintenance of a fund of this character, and that he personally had no choice in the matter, although he said he recognized the merit of the suggestion made by the Policy Committee.

In concluding his summary of changes in the medical program, Mr. Stillman commented as follows:

> "This seems the best we can do under the circumstances. It should be borne in mind always that the FERA may carry out the desire of the President of the United States to hold political subdivisions responsible for meeting relief needs after the works program gets underway. If this is done, it may be necessary for us to abrogate the above proposals. I want to assure you, however, that we appreciate the difficulties under which the physicians of the state have been working, and I ask (and I am sure you are already thinking so) that you have in mind the financial limitations of my own program.
>
> "At any rate, I think we have rendered a little bit of improvement and I am glad we are able to show, even though it be in a small way, our appreciation of the sacrifice that is being made by the great majority of the medical profession in the State of Ohio.
>
> "The committee of the State Medical Society has been a very cooperative and considerate group, and I regret only that I cannot go much farther in our proposal."

The Policy Committee is well aware that the foregoing plan is not perfect and perhaps will not meet the situation in some counties. At the same time, the committee believes it is a considerable improvement over the one which has been in operation since the Fall of 1933. The committee is disappointed that some plan could not have been established which would have permitted a more equitable distribution of the total amount of money available each month for medical care in the state as a whole and perhaps have permitted a somewhat larger per capita allocation. However, the committee appreciates the inelasticity of the federal accounting regulations as well as the financial limitations of the entire relief program.

This fact should not be overlooked. Had the new program been in effect during the month of April, approximately $50,000 additional would have been available in the state as a whole for paying physicians', dentists' and nurses' fee bills. In April, $34,000 in round figures were paid out for medical supplies before any funds were paid out for professional services. Moreover, in the month of April there were approximately 65,000 single persons on relief, which would have increased by about $16,000 the total funds available for professional services. Approximately $187,500 was spent for medical care in April. Under the new plan, this amount could have been about $237,500.

The Policy Committee is of the opinion it has been able to bring about a number of very desirable improvements in the medical plan, making it possible for local relief administrations to deal more liberally with physicians. The committee feels that through careful supervision and active participation by the medical advisory committees which will be established, material savings can be brought about and pro-rating made unnecessary in most instances. The committee is of the opinion that it has established a most cordial and cooperative relationship between the Ohio State Medical Association and Relief Administrator Stillman and his staff, and is hopeful that additional improvements in the medical program can be secured from time to time.

It is suggested that the members of the Council discuss the changes in the medical set-up with the county societies of their respective districts at the earliest possible date, and encourage physicians of their districts to give the new set-up a fair trial. The Policy Committee will continue its negotiations and endeavor from time to time to secure more equitable adjustments in the medical plan.

It is hoped that the officials of all county medical societies will immediately confer with their local relief director, offer their cooperation, and especially request him to make available for professional services the full amount allowed by the budget set up in the revised plan. Failure on the part of any local relief director to cooperate with the local medical profession should be reported to our state headquarters office so that the matter can be taken up with the proper officials at the state relief office.

On *motion* by Dr. Davidson, seconded by Dr. Klotz and *carried*, the Council *approved* the changes in the medical relief plan authorized by Mr. Stillman; expressed the belief that the new

program, although not satisfactory in all respects, will be a decided improvement over the plan which has been in operation for the past 18 months, and commended the Policy Committee for its activities and negotiations resulting in the important modifications of the medical relief plan.

On *motion* by Dr. Klotz, seconded by Dr. Kirkland and *carried*, the Executive Secretary was instructed to communicate with Mr. Stillman expressing the appreciation of the Council for his considerate and cooperative attitude; thanking him for authorizing changes in the medical relief plan in line with some of the recommendations of the Ohio State Medical Association, and pledging the assistance of the Ohio State Medical Association in putting the new plan into effect and in bringing about from time to time additional improvements in it.

On *motion* by Dr. Huston, seconded by Dr. Beer and *carried*, the headquarters office was instructed to communicate with the officers of each county society or academy of medicine, notifying them of the changes to be made in the medical relief set-up and suggesting to them that they disseminate in writing, if possible, the important points of the revised plan to their memberships and that they request all physicians rendering service to those on relief to cooperate with their local relief administration and adhere strictly to all rules and regulations governing the medical relief program.

During the discussion of the foregoing motion, several members of the Council pointed out that some of the difficulties which have arisen in connection with the medical relief program have been the result of the failure of a few physicians to cooperate with their local relief office and of abuses such as over-charging, rendition of excessive treatment, etc., on the part of a small minority of the medical profession, which, in some instances, has made it necessary for local relief administrations to resort to pro-rating of bills submitted by all physicians. The sentiment was expressed that all county societies and academies should make a strenuous effort to prevent questionable practices of this character which have reflected unjustly on the reputation of the medical profession as a whole and have unfairly penalized the great number of honest and conscientious physicians engaged in rendering service to relief patients.

On *motion* by Dr. Davidson, seconded by Dr. Seiler and *carried*, the Policy Committee was requested to continue its negotiations with Mr. Stillman and to take up with him at the earliest possible date the following:

1. The possibility of securing special grants for those counties where it has been found necessary to pro-rate physicians' bills during the months of January, February, March, April and May, 1935, so that such bills can be paid in full.

2. The insertion of more definite provisions in the Rules and Regulations concerning the treatment of, and fees to be allowed for, chronic cases.

3. Methods that should be followed and fees paid to physicians in the treatment of relief clients having venereal diseases.

4. Tightening up of the Rules and Regulations relative to refraction, dentures and the purchase of glasses.

5. The proper fee for minor operations performed in the physician's office or the home of the relief client.

The question of the vendor's certificate which physicians rendering service to those on relief are required to sign, was discussed. It was pointed out that such certificate has no connection with the Ohio Retail Sales Tax, but is a blank issued by the federal government. It must be filled out by all persons furnishing materials and supplies to agencies financed with federal funds and certifies that the vendor has complied with the federal tax laws and the various industrial or business codes which had been set up under the NRA. A communication from the Ohio FERA office was presented, stating that the signing of this vendor's certificate is merely a routine provision and that physicians do not necessarily have to sign one unless they furnish drugs or supplies to a relief client.

QUESTIONS OF MEDICAL CARE TO RECIPIENTS OF OLD AGE PENSIONS

Dr. Upham reported that the Policy Committee had considered a communication under date of May 3, 1935, by H. J. Berrodin, Chief of the State Division of Aid for the Aged, to county investigators of that division, in which Mr. Berrodin requested information relative to local medical services available to recipients of old age pensions, and a resolution on this matter adopted on May 17, 1935, by the Licking County Medical Society, a copy of which had been submitted to the state headquarters office. Dr. Upham stated it was the opinion of the Policy Committee that those receiving old age pensions should be classed as permanent indigents and that any supplemental relief, including medical care, required by them should be provided by local subdivisions charged with the responsibility of providing relief for this class of indigents. He pointed out that the Policy Committee believes that the recipients of old age pensions, if unable to provide medical service for themselves and unable to make satisfactory arrangements with their family physicians, should be cared for in already established clinics, dispensaries or other local facilities for providing medical care for permanent indigents. He stated the committee disapproved of the suggestion that a special fund be allocated to or established in each county by the State Division of Aid for the Aged to provide medical service for such persons, pointing out the committee felt the

establishment of an additional system of medical service under governmental control such as this is unnecessary and inadvisable.

On *motion* by Dr. Hendershott, seconded by Dr. Seiler and *carried*, the Council concurred in the statements submitted by the Policy Committee and instructed the committee to hold further conferences with Mr. Berrodin. Members of Council during the discussion of the motion expressed the belief that recipients of old age pensions should be encouraged to seek medical care from their family physicians who could use their own discretion on the matter of accepting them as private patients or referring them to local agencies set up to care for indigents who are charges of local subdivisions. Also, it was pointed out that in all probability arrangements might be made with local FERA directors to provide medical care for old age pensioners whose monthly compensation is insufficient to meet their budgetary requirements.

STATE INDUSTRIAL COMMISSION ASKED TO RESCIND 20% REDUCTION IN MEDICAL AND SURGICAL FEE BILLS

Dr. Hein, special member of the Committee on Medical Economics and chairman of the former special Committee on Workmen's compensation, submitted to the Council a report summarizing the improved financial status of the workmen's compensation insurance fund and recommending that the Council officially request the State Industrial Commission to rescind the 20 per cent reduction in medical and surgical fee bills authorized by the Industrial Commission in the Spring of 1933.

The statement presented by Dr. Hein was as follows:

On April 1, 1933, the State Industrial Commission ordered a temporary reduction of 20 per cent on medical and surgical bills for services rendered in workmen's compensation cases.

That action was taken when the depression was at its peak, the State Industrial Commission was confronted with critical financial problems, and the Commission felt that immediate steps to reduce the expenditures from the state insurance fund were necessary and expedient.

Since that time economic conditions generally have improved and a distinct improvement has taken place in the status of the state insurance fund.

This is shown through comparison of the following data secured during the past two weeks from the records of the State Industrial Commission:

Year Ending 12-31	Receipts	Disbursements	Reserve
1931	$12,677,541.74	$17,457,582.10	$41,961,501.37
1932	9,285,335.29	15,733,294.67	38,806,775.00
1933	10,373,629.07	13,908,453.73	35,408,913.08
1934	16,231,898.99	13,252,425.39	
Jan. 1935	1,006,075.70	1,210,222.80	
Feb. 1935	1,399,598.93	992,126.24	
Mar. 1935	1,640,627.66	1,234,010.15	
Apr. 1935	1,505,161.41	1,078,235.35	

These statistics indicate that the workmen's compensation system is no longer confronted with a financial crisis and that most of the difficulties before the Commission two years ago have been, or are rapidly being, solved.

The foregoing figures show that in 1934—the first full year during which the 20 per cent discount in medical fees was in effect—the total receipts of the Industrial Commission exceeded the total disbursements by approximately $3,000,000. In 1933 the disbursements had exceeded the receipts by about $3,500,000.

Although in January, 1935, the disbursements exceeded receipts by approximately $200,000, in the months of February, March and April, respectively, a substantial surplus was accumulated, indicating steady improvement in the financial affairs of the Commission.

Analysis of the figures on average compensation and average medical costs shows that the average medical award in 1933 was 23 per cent less than in 1932 and the average medical award in 1934 was 34 per cent less than in 1932, the peak year in medical costs. In January, 1935, the average medical award was 26 per cent less than the average for the year 1932; in February, 1935, 34 per cent less; and in March, 1935, 34 per cent less.

Although the average compensation award has decreased since 1932, the decrease has not been comparable to that made in medical costs, being 8 per cent in 1933; 27 per cent in 1934; 20 per cent in January, 1935; 18 per cent in February, 1935, and 33 per cent in March, 1935.

A careful study of the foregoing data indicates conclusively:

1. The "emergency" which confronted the Industrial Commission in the Spring of 1933 has disappeared.
2. The state insurance fund is in a sound condition and there is a steady and decided

AWARDS

	New Claims Filed	Compensation	Medical	Average Comp.	Average Med.
1931	163,800	$12,230,782.35	$4,889,308.20	$74.67	$29.85
1932	126,308	11,131,808.03	4,196,199.15	88.13	33.22
1933	126,949	10,360,780.61	3,258,781.87	81.61 (8 %)	25.67 (23%)
1934	150,218	9,760,707.09	3,302,193.21	64.98 (27%)	21.98 (34%)
Jan. 1935	11,443	814,103.78	284,757.17	71.14 (20%)	24.88 (26%)
Feb. 1935	10,499	763,611.96	229,863.14	72.73 (18%)	21.89 (34%)
Mar. 1935	12,652	751,430.67	272,646.03	59.39 (33%)	21.55 (34%)
Apr. 1935	12,433				

trend toward an excess of receipts over disbursements.

3. The medical profession, whose bills for services rendered have been subject to a 20 per cent discount, has contributed substantially toward the savings which are being made by the Commission and which have aided the Commission decidedly in meeting its financial difficulties.
4. Medical costs have decreased at a ratio considerably greater than the 20 per cent reduction in medical bills and the decreases obtained have been uniformly greater than those made in compensation costs.
5. The medical profession generally has cooperated with and assisted the Commission during a period of financial stress by making a contribution amounting to considerably more on the average than the 20 per cent reduction in medical fee bills and by adhering conscientiously to the rules and regulations of the Commission.

For the foregoing reasons, the Council of the Ohio State Medical Association, speaking officially for the medical profession of the state, respectfully requests the State Industrial Commission to immediately rescind the temporary reduction of 20 per cent on medical and surgical bills and to authorize payment in full of physicians rendering medical service to workmen's compensation claimants in accordance with the Medical and Surgical Fee Schedule, adopted in 1920 and still in effect.

In conjunction with this request, the Council desires to again express appreciation to the State Industrial Commission for the fair and reasonable attitude the Commission has shown toward the medical profession of Ohio. It pledges medical organization to continued cooperation and assistance in administration of the Workmen's compensation Law. It offers the Commission the support and cooperation of the Ohio State Medical Association in the maintenance and inauguration of sound and practical methods of improving the workmen's compensation system and in efforts to eliminate abuses and violations on the part of any coming within the purview of the workmen's compensation system.

On *motion* by Dr. Huston, seconded by Dr. Brush and *carried*, the Council concurred in the foregoing statement and instructed the Executive Secretary to officially transmit to the State Industrial Commission the request for revocation of the 20 per cent discount in physicians' bills.

PAST, PRESENT AND FUTURE LEGISLATIVE PROBLEMS

A report on the recently terminated regular session of the Ohio General Assembly was made by Dr. Upham, chairman of the Policy Committee, the high spots of which were as follows:

1. Despite strong political pressure and the activities of well-paid lobbies, the osteopathic, chiropractic and Christian Science bills were killed in committee.

2. An unusually large number of bad bills seeking to amend the Workmen's Compensation Law were introduced. Several were approved by at least one house of the General Assembly, but none was finally enacted.

3. A bill to require all county coroners to be physicians, and another abolishing the coroner system and substituting the so-called medical-examiner plan, failed of enactment.

4. No measures detrimental to public health were enacted. A proposal to require public health nurses to be registered nurses was approved and signed by the Governor. A uniform narcotic drug act was enacted, modernizing regulation by the state of the use, sale and handling of narcotic drugs.

5. Most of the bills sponsored by the Commission on Reorganization of County Government were defeated.

6. No bills levying new taxes were enacted.

7. An automobile drivers license bill was passed by both houses, but vetoed by the Governor. A drivers financial responsibility bill was enacted and signed by the Governor.

8. No social insurance proposals were enacted, although approximately a dozen proposals for unemployment insurance, pensions of various types and one providing for a health insurance system were considered.

Dr. Upham called particular attention to the necessity for concerted legislative activity on the part of the medical profession during the ensuing months due to the fact that several important special sessions of the State Legislature may be anticipated. He pointed out that a special session of the General Assembly next Fall to consider taxation and finances is inevitable, and that proposed legislation of special interest to the medical profession undoubtedly will be considered at that time, including an income tax measure, a proposed gross receipts tax, and a bill to provide for the extension of the present retail sales tax to professional and non-professional services.

The possibility of a special session to consider changes in and additions to the Workmen's Compensation Law also was discussed. It was pointed out that undoubtedly changes in the compensation law would be recommended by the Sherrill Investigating Commission which recently completed its survey of various state departments, boards, commissions, etc., and that in all probability some modification of the workmen's compensation system will be recommended by the special committee of the Ohio Senate now engaged in an investigation of the State Industrial Commission.

Dr. Upham called attention to the fact that there probably would be a special session to consider proposals for various types of social insurance. He pointed out that the General Assembly deferred action on unemployment insurance, revision of the old age pension law, etc., pending the outcome of proposed social security legislation in the United States Congress. He reported that there is strong pressure for the enactment of a social insurance program in Ohio regardless of the outcome of the federal proposals, and that the

program which doubtless will be presented to the Ohio Legislature may include one or more proposals for compulsory state health insurance.

For these reasons, Dr. Upham stated it is vital that all legislative committeemen be constantly on the job to strengthen their contacts with members of the present Legislature. He pointed out that it is highly important that all physicians immediately express appreciation to those legislators who deserve it and make use of every opportunity during the ensuing months to present to them the concerted viewpoint of the medical profession on questions of taxation, workmen's compensation, health insurance, etc. On *motion* by Dr. Hendershott, seconded by Dr. Jenkins and *carried*, the Council commended the Policy Committee on its successful activities in connection with the regular session of the State Legislature, and expressed its appreciation to all local legislative committeemen who had faithfully cooperated with the committee and rendered meritorious service by contacting and interviewing their respective legislators.

SUPPLEMENTAL REPORT OF THE COMMITTEE ON EXTENSION OF ACTIVITIES

The Special Committee on Extension of Activities reported to the Council that it was not prepared at this time to submit additional recommendations on matters previously submitted to the Council but deferred pending further consideration. On *motion* by Dr. Davidson, seconded by Dr. Brush and *carried*, the committee was authorized to continue its activities and to submit by mail to members of the Council recommendations which would require amendments to the Constitution and By-Laws of the State Association so that official approval could be obtained previous to the next Council meeting and the proposed amendments, if any, published in *The Journal* and transmitted to the county medical societies as required by the Constitution and By-Laws.

ANNUAL MEETING ARRANGEMENTS

In the absence of Dr. Smith, chairman of the Council Program Committee and the Council Committee on Arrangements, Dr. Caldwell, the President, reported on arrangements for the 1935 Annual Meeting in Cincinnati, Wednesday, Thursday and Friday, October 2, 3 and 4. He stated that with one or two exceptions the program has been completed and that local arrangements for the meeting are being satisfactorily handled by committees of the Cincinnati Academy of Medicine. On behalf of Dr. Smith, he informed the Council that the entire program would be ready for official action and approval by the Council at its next regular meeting. Dr. Caldwell also reported that the commercial exhibit space is rapidly being disposed of, as well as space provided for the scientific exhibits.

A. M. A. CONFERENCE ON MEDICAL ECONOMICS

Dr. Bigelow, chairman of the Committee on Medical Economics, submitted a verbal report on the Conference on Medical Economics held in Chicago, April 27, under the auspices of the American Medical Association, and which he had attended as the official representative of the Ohio State Medical Association. The purpose of the conference, Dr. Bigelow said, was to obtain information and discussion on various experimental plans of providing medical service to indigents and those belonging to the low income classes, in order that the A. M. A. Bureau of Medical Economics might have authentic data and recommendations for submission to the House of Delegates of the A. M. A. at the 1935 meeting in Atlantic City. Dr. Bigelow stated the following were among the important questions discussed at the Chicago conference: (1) The importance of consultation and cooperation between individual county medical societies and the state medical association on medical service plans. (2) Methods to be used in collecting data on plans now in operation. (3) Studies of the operation of hospital clinics and dispensaries. (4) Survey of the industrial and group clinics, contract practice, etc. (5) Collection of accurate information on percentage of population not receiving adequate medical attention to counteract false statistics frequently published on this question. (6) Advisability of competent legal advice before any plan is put into effect. (7) The need, if any, for numerous special facilities which have been established for special groups, such as crippled children, tuberculars, mentally sick, etc. (8) Mechanics for the operation and control of medical service plans. (9) What groups should receive such service and what economic standards should be set-up? (10) Various methods of pre-payment or deferred payment for services received.

Dr. Bigelow stated that a detailed account of the conference would be submitted to the A. M. A. House of Delegates by Dr. R. G. Leland, Director of the Bureau of Medical Economics of the A. M. A., and he suggested that the members of Council study that report carefully when available.

On *motion* by Dr. Huston, seconded by Dr. Davidson and *carried*, the Council expressed appreciation to Dr. Bigelow for attending the Chicago meeting and for his pertinent remarks concerning its transactions.

MISCELLANEOUS

Dr. Caldwell, the President, announced that the financial accounts of the State Association and *The Journal* for the calendar year 1934 and the same accounts up to March 15, 1935, the date of the resignation of Former Executive Secretary Martin, had been audited by a firm of certified public accountants and certified as correct.

On *motion* by Dr. Brush, seconded by Dr. Jenkins and *carried*, the Council authorized the

Executive Secretary to accept dues for *new* members in the State Association from July 1 to October 1 on a pro-rata basis of $3.00, and from October 1 to December 31, at $2.00, but that no rebate should be made to members whose dues are accepted on a pro-rata basis.

It was announced that the membership of the State Association as of June 1, 1935, was 5,126, compared with 5,028 on June 1, 1934 and with the total for last year of 5,361.

There being no further business, the Council adjourned to meet at the call of the President, probably the first or second Sunday in August.

Signed: JAMES A. BEER, M.D.,
Acting Secretary of Council.

REVISED FERA MEDICAL PLAN, PROVIDING MORE FUNDS FOR PAYMENT OF PHYSICIANS' BILLS, ESTABLISHED AS RESULT OF POLICY COMMITTEE'S NEGOTIATIONS

AS a result of intensive activities by the Policy Committee of the Ohio State Medical Association, culminating in the submission of definite recommendations to State Relief Administrator C. C. Stillman, a revised FERA medical plan has been authorized by Mr. Stillman, effective July 1.

The new plan, which has been approved by The Council of the State Association, will, it is hoped, make available in every county sufficient funds to pay physicians, dentists and nurses *in full* for services to those on the FERA relief rolls and give each county medical society or academy an opportunity to actively participate in the administration of the medical relief program.

Detailed regulations governing the new plan are now being worked out jointly by members of Mr. Stillman's executive staff and representatives of the Ohio State Medical Association. They will be transmitted to local relief administrators, it is anticipated, in time to have the plan in operation by July 1.

IMPORTANT PROVISIONS SUMMARIZED

The major provisions of the revised plan are as follows:

1. An amount of money equal to the sum obtained by multiplying $1.00 by the number of current family relief cases and $.25 by the number of current single relief cases, exclusive of transients, will be available in each county for medical, dental and nursing services for those on relief.

2. The cost of drugs and medical supplies will be considered apart from the costs of medical, dental and nursing services. That is, bills for drugs and medical supplies authorized by the local relief administration will be paid from other direct relief funds and not from the fund available under the $1.00 per family and $.25 per single person allowances.

3. The fee schedule used under the former medical plan will be followed.

4. An effort will be made by the State Relief Administration to have each county reief director set up on a voluntary basis an advisory committee composed of a physician, a dentist, a nurse, a pharmacist and the relief director or his proxy. In formulating this committee, the local relief director will be expected to secure the cooperation and assistance of the county medical society and societies representing the local dental, nursing and pharmaceutical professions.

In notifying the Policy Committee of the changes authorized, Mr. Stillman pointed out that he had hoped to place the new plan into operation during the month of June, but had found the budget procedure for that month had reached a stage whereby he was precluded from applying the plan to that month. He said, however, that the new program would be taken into consideration when budgets for the month of July are formulated and approved.

SUBSTANTIAL INCREASE IN FUNDS PROVIDED

A careful analysis of the changes approved by Mr. Stillman shows that the new plan will be a decided improvement over the one that has been in effect since the Fall of 1933. Application of the new plan to the situation that existed in the month of April, the last month for which complete figures are available, illustrates this point.

In April, 264,701 families in the state as a whole were on direct relief. Therefore, the total amount of money available for the medical program throughout the state, including both services and medical supplies, was $264,701. Expenditures during April for drugs and medical supplies totaled $34,044.94, leaving a balance of $230,756.06 available to pay the bills of physicians, dentists and nurses.

Had the revised medical plan been in effect in April, the full amount of $264,701, plus $16,429.50 (65,718 single relief cases multiplied by $.25), or a total of $281,130.50 would have been available to be used exclusively in paying bills of physicians, dentists and nurses. The bills for drugs and supplies amounting to $34,044.94 would have been paid out of other relief funds, entirely

apart from the maximum allowance permitted for the payment of bills for professional services.

In this connection the Policy Committee has learned by checking the records of the state relief headquarters and from data secured from the various county medical societies that in many counties it has been found necessary in the past to pro rate physicians' bills partially because of the substantial amounts paid out for drugs and medical supplies, which, under the old plan, had to be paid out of the fund for medical care before physicians' bills could even be considered.

Separation of bills for drugs and supplies from those for professional services will, it is believed, make it possible for most county relief directors to pay physicians' bills in full.

ADVISORY COMMITTEE PLAN WELCOMED

Mr. Stillman's action in authorizing and encouraging the formation of a medical advisory committee in each county should meet with the hearty approval of the medical profession generally. It is in line with recommendations repeatedly made by the State Medical Association.

In this connection, it is planned to have the physician members of the advisory committee serve as a medical adviser to the local relief administration and assist in validating bills for professional services. Should the medical adviser choose to give a designated number of hours, up to three or four a day, for field service, arrangements may be made for placing him on a salary. Otherwise he would serve on a voluntary basis as adviser and if engaged in caring for relief patients, paid in accordance with the uniform fee schedule.

As pointed out by the Policy Committee in its report to The Council (minutes of June 2 meeting of the Council, pages 528-534) the medical advisory committee will play an important role in making the revised medical plan a success. It can be of great assistance in bringing about efficient supervision of the program to insure adequate medical care of those on relief and prevent overcharging and excessive treatment. Through active participation of the medical profession through the local advisory committee, material savings may be brought about and prorating made unnecessary in many instances.

FOUND CENTRAL POOL IDEA IMPRACTICAL

In pointing out why he had been unable to accept one of the important recommendations of the Policy Commitee, i.e., the establishment of a central pool of the funds for medical care from which allocations could be made to individual counties on the basis of actual need, Mr. Stillman stated:

"It is not permissible to allow any unused money for any month in any one county to be held over for application to the medical costs in such county in a succeeding month or to transfer any unused balances in any county for use in other counties in the same or succeeding months."

"It is hoped that the officials of all county medical societies will immediately confer with their local relief director, offer their cooperation, and especially request him to make available for professional services the full amount allowed by the budget set up in the revised plan. Failure on the part of any local medical profession should be reported to our state headquarters office so that the matter can be taken up with the proper officials at the state relief office."—(Excerpt from report of Policy Committee to the Council).

Mr. Stillman pointed out that rigid accounting regulations have been established by the federal government which prohibited the maintenance of a fund of this character, and that he personally had no choice in the matter, although he said he recognized the merit of the suggestion made by the Policy Committee.

In concluding his summary of changes in the medical program, Mr. Stillman commented as follows:

"This seems the best we can do under the circumstances. It should be borne in mind always that the FERA may carry out the desire of the President of the United States to hold political subdivisions responsible for meeting relief needs after the works program gets underway. If this is done, it may be necessary for us to abrogate the above proposals. I want to assure you, however, that we appreciate the difficulties under which the physicians of the state have been working, and I ask (and I am sure you are already thinking so) that you have in mind the financial limitations of my own program.

"At any rate, I think we have rendered a little bit of improvement and I am glad we are able to show, even though it be in a small way, our appreciation of the sacrifice that is being made by the great majority of the medical profession in the State of Ohio.

"The committee of the State Medical Society has been a very cooperative and considerate group, and I regret only that I cannot go much farther in our proposal."

CONFERENCES TO BE CONTINUED

The Policy Committee, acting upon instructions of the Council, will continue its conferences with Mr. Stillman and will endeavor to work out with him from time to time additional improvements in the medical relief procedure.

It has found Mr. Stillman sympathetic with the viewpoint of the medical profession and sincerely interested in trying to establish a medical plan that will meet with the approval of the medical profession. He has frankly admitted that the plan to be placed in operation July 1 is not perfect and has promised additional changes when finances and circumstances will permit.

Special attention of the membership is called

to that section of the Council minutes, (page 530) recording the action of the Council in criticizing those few physicians who have been guilty of abuses and dishonest practices in connection with the medical relief program and in requesting all county medical societies and academies to make every effort to eliminate such abuses and prevent dishonest physicians from participation in the medical program.

MANUAL ON PAPER WORK AVAILABLE

It is suggested that all physicians caring for relief clients obtain from their local relief director, if they have not already done so, a copy of the Revised Accounting and Purchase Procedure Manual issued to local relief administrations the middle of May.

That portion of the manual pertaining to accounting procedure in connection with medical service is of particular importance.

The manual contains sample copies of various forms physicians are required to fill out and file, accompanied by explanatory notes on the procedure.

Some of the more important regulations contained in the manual are as follows:

Emergency Calls—In the case of emergency calls, the client contacts his physician and secures the immediate service needed. The case must be reported to the Social Service Department the following day by the physician, and the regular procedure should be followed. One call will be allowed as an emergency.

EASY WAY TO SECURE CLIENT'S SIGNATURE

In order that the physician may secure the signature of the client in cases where he only makes an emergency call, it is suggested to the local relief director that he mimeograph a receipt form (sample shown in manual) and leave a pad of this form with each physician, instructing him to secure the signature of the client at the time he makes the emergency call. The physician is required to attach the form having the relief client's signature on it to the Relief Order No. 132 when submitting the relief order to the county relief office for payment. The form also must accompany the relief order when vouchered and submitted to Columbus for payment.

This new procedure is in line with one of the recommendations of the Policy Committee of the State Medical Association and meets an objection that has been raised that physicians had heretofore been required to make an extra call on a patient, without compensation, in instances where the original call was made before the physician had received the relief order from the county relief office:

Authorized Calls—For anticipated medical needs, the case worker places a requisition on the Order-Writing Department for medical attention. The Order-Writing Department issues a Relief Order Form No. 132 (attached to RM 2003 and RO 2004) specifying the number of calls to be made and sends the white No. 132 Form and pages No. 2 and 3 of RM 2003 or RO 2004 to the physician, dentist or registered nurse. (A sample order filled out for four authorized home calls is published in the manual).

The physician, dentist or registered nurse renders the service, secure the client's signature in the space provided, itemizes his or her calls on Form No. 132, signs the vendor's certificate and fills out the lower portion of Form RM 2003 or RO 2004. He or she then returns Form No. 132, Page 2 of RM 2003 or RO 2004 to the county relief administration along with four copies of Form 774. Instructions also are given relative to filling out of Form 774 which is in effect a summary of relief supply orders received by the physician during the month.

NEW PROCEDURE ON MILEAGE ALLOWANCE

Mileage—The charges for mileage must be included as a part of the medical service and cannot be shown as a separate item on Form No. 132. The physician should show mileage on Forms RM 2003 or RO 2004 but on Form 132 the figure filled in must represent the fee allowed for the visit plus the mileage allowance.

Of course, the procedure relative to pro-rating outlined in the manual will have to be revised in accordance with the new regulations separating the cost of drugs and medical supplies from the cost of professional services.

—OSMJ—

Post Graduate Program for Alumni

As part of the program of commencement week, alumni of the School of Medicine of Western Reserve University had continuation conferences on Tuesday, June 11. Reports of progress in the various branches of medicine and surgery were summarized. Discussions were led by the following: Drs. J. A. Toomey, J. D. Pilcher, W. Heymann, A. J. Horesh, C. F. Good, C. E. Zeithaml, J. H. Davis, C. F. Ulrich, Marion Douglass, J. T. Smith, Eugene Freedman, M. A. Blankenhorn, G. S. Shibley, A. J. Beams, T. D. Spies, J. A. Bender, J. R. Driver, F. R. Miller, J. T. Wearn, J. M. Hayman, Jr., R. H. Birge, Maxwell Harbin, D. M. Glover, E. F. Bright, J. W. Holloway, E. P. Judd and W. C. McCally.

—OSMJ—

Legal and medical problems pertaining to the examination and prosecution of persons involved in traffic accidents by reason of intoxication will be studied by a joint committee of the Cincinnati Bar Association and the Cincinnati Academy of Medicine.

MANY OHIO PHYSICIANS PRESENT AT RECORD A.M.A. MEETING; BUCKEYE DELEGATES TAKE ACTIVE AND PROMINENT PART

FEATURED by a record attendance and doubtless one of the finest scientific programs ever presented before a medical gathering in the United States, the Eighty-Sixth Annual Session of the American Medical Association was held June 10-14 at Atlantic City.

Between 8,000 and 8,500 Fellows of the A.M.A. registered, a mark well in excess of the record established several years ago when the meeting was held at Chicago.

The medical profession of the United States had as its guests several hundred members of the Canadian Medical Association which held its Sixty-Sixth Annual Session at the same time, representatives of both organizations contributing to the excellent joint scientific program.

A large number of Ohio physicians took part in the scientific activities of the session as essayists, discussants or scientific exhibitors. Incidentally, the scientific exhibit was pronounced by many who attended as the best ever held by the American Medical Associatoin. The names of those who took part in the program and exhibit were published in the June issue of *The Journal*, pages 459-460.

Among those who received awards for their exhibits was Dr. C. C. Higgins, Cleveland, who was awarded a certificate of merit, class No. 2, for excellence of presentation of his exhibit on transplantation of ureters.

OHIO DELEGATES TAKE ACTIVE PART

Ohio, as usual, took a prominent part in the transactions of the House of Delegates, being represented by Drs. Ben R. McClellan, Xenia; Wells Teachnor, Sr., Columbus; J. P. DeWitt, Canton; C. W. Waggoner, Toledo; C. W. Stone, Cleveland, and E. R. Brush, Zanesville, representing the Ohio State Medical Association and Dr. C. L. Cummer, Cleveland, representative of the Section on Dermatology and Syphilology.

Dr. McClellan served as a member of the important House of Delegates Reference Committee on Records of Officers and Dr. Waggoner served as chairman of the Reference Committee on Rules and Order of Business.

Dr. J. H. J. Upham, Columbus, and Dr. Geo. Edw. Follansbee, Cleveland, took a prominent part in the activities of the House of Delegates. Dr. Upham, as retiring chairman of the Board of Trustees, presented the annual report of the Board and frequently submitted reports on behalf of the Board relative to new business referred to it for study. Dr. Follansbee, chairman of the Judicial Council, presented the annual report of the Council and submitted several supplemental reports on important questions that arose during the transactions of the House of Delegates.

The House of Delegates heard and discussed in detail a special report submitted by the Bureau of Medical Economics of the A.M.A., analyzing numerous plans for distributing medical service now in effect in many parts of the country and emphasizing the good and bad features of each. The submission of the report was in compliance with the request made at the special meeting of the House of Delegates held in Chicago last February at which the principles adopted at the 1934 meeting in Cleveland were re-emphasized and the stand of organized medicine against all forms of compulsory sickness insurance was re-affirmed. (See July, 1934, issue of *The Journal*, page 446 and March, 1935, issue, pages 212-213).

The principles previously adopted were reaffirmed at the Atlantic City meeting and the Bureau of Medical Economics was instructed to continue with its study of individual experiments in an effort to work out different plans which conform to the basic principles approved by the A.M.A. and which can be adapted to individual communities.

Several resolutions relative to birth control were presented and by action of the House of Delegates all were referred to the Board of Trustees which was instructed to appoint a special committee to study the question and report at the 1936 meeting.

NEW OFFICERS ARE ELECTED

At the closing session of the House of Delegates, it was voted to hold the 1936 meeting at Kansas City, Missouri, and the following officers were elected: President-elect, Dr. James Tate Mason, Seattle, Washington; secretary and general manager, Dr. Olin West, Chicago; treasurer, Dr. Herman L. Kretschmer, Chicago; speaker of the House of Delegates, Dr. Nathan B. Van Etten, New York City, succeeding Dr. F. C. Warnshuis, San Francisco; vice speaker of the House of Delegates, Dr. H. H. Shoulders, Nashville, Tennessee, succeeding Dr. Van Etten; trustees, Dr. Ralph A. Fenton, Portland, Oregon, and Dr. James R. Bloss, Huntington, West Virginia, succeeding Dr. Joseph A. Pettitt, Portland, Oregon, and Dr. J. H. J. Upham, Columbus, whose terms expired and who were ineligible for re-election under the Constitution and By-Laws.

DR. FOLLANSBEE RE-APPOINTED

Dr. James S. McLester, Birmingham, Alabama, who was inaugurated as president for 1935-36, succeeding Dr. Walter L. Bierring, Des Moines, made the following appointments which were approved by the House of Delegates: Judicial Council, Dr. Geo. Edw. Follansbee, Cleveland; Coun-

cil on Medical Education and Hospitals, Dr. Reginald Fitz, Boston; and Council on Scientific Assembly, Dr. Alfred A. Walker, Birmingham, Alabama.

Approximately 350 Ohio Fellows of the A.M.A. attended the meeting. Among those who registered were:

AKRON—Paul R. Adams, P. T. Arapakis, Millard C. Beyer, Theodore L. Bliss, D. C. Brennan, Harold R. Conn, P. A. Davis, Clarence L. Hyde, Carl E. Krill, Charles N. Long, D. B. Lowe, Wm. D. Lyon, C. L. McDonald, Noah Miller, A. P. Ormond, G. K. Parke, Dallas Pond, Howard W. Reed, Fowler B. Roberts, Louis Sheinin, Carl R. Steinke, Joseph M. Ulrich, Karl D. Way, Edmund A. Weeks.

CANTON—H. W. Beck, J. P. DeWitt, C. E. Fraunfelter, E. Gillespie, Fred G. King, E. O. Morrow, H. M. Schuffell, J. E. Shorb, L. D. Stoner, Homer V. Weaver, George F. Zinninger, Pauline Zinninger.

CINCINNATI—Theodore Bange, Julien E. Benjamin, Harry M. Box, W. L. Brodberger, Albert L. Brown, Susan W. Brown, Ralph F. Carothers, George E. Clarke, Charles Ross Deeds, Carroll J. Fairo, Nancy E. Finney, Joseph A. Freiberg, Mabel E. Gardner, Samuel Goldblatt, Harry Goldstein, Motimer Herzberg, Louis G. Herrmann, Charles E. Howard, Benjamin Hoyer, D. E. Jackson, K. V. Kitsmiller, Arthur L. Knight, Robert H. Kotte, Harry O. Lepsky, Joseph Lindner, J. E. McCarthy, Johnson McGuire, A. Graeme Mitchell,

A. W. Nelson, Evalyn A. Partymiller, Helena T. Ratterman, Horace W. Reid, Mont. R. Reid, Harold G. Reineke, Andrew Renz, D. C. Rivers, Clyde R. Roof, Leon Schiff, Bernard A. Schwartz, Paul W. Sutton, Cecil Striker, E. B. Tauber, Edward R. Thomas, Derrick T. Vail, Jr., A. R. Vonderahe, P. F. Weil, Charlotte Wiedemer, Mendel Zeligs.

CLEVELAND—Sol. B. Abrams, Herman S. Applebaum, C. Glenn Barber, N. S. Banker, Geo. I. Bauman, E. E. Beard, Claude S. Beck, Ralph M. Bone, E. R. Brooks, Jacob L. Bubis, H. Van Y. Caldwell, Roland A. Case, M. B. Cohen, Wm. M. Champion, Harold N. Cole, Samuel B. Cowen, George W. Crile, Clyde L. Cummer, Nicholas S. D'Alessandro, James A. Dickson, Charles T. Dolezal, Robert S. Dinsmore, Frank J. Doran, James R. Driver, Wallace Duncan, I. H. Einsel, Oscar Eisinger, Charles W. Emmons,

Warren C. Fargo, Harold Feil, George E. Follansbee, J. Edgar Fisher, W. J. Gardner, C. Lee Graber, Russel L. Haden, John E. Hannibal, C. L. Hartsock, Harry Hauser, Frederick C. Herrick, C. H. Heyman, Charles C. Higgins, Henry J. John, Thomas E. Jones, Benjamin S. Kline, W. B. Landesman, C. G. LaRocco, Thomas M. Lees, Hugh J. Leslie, Edward A. Levin, Wm. E. Lower, Roswell Lowry, Herbert A. Mahrer, E. A. Marshall, James J. Marek, Philip Marvel,

Raymond V. May, John J. McCarthy, E. P. McCullagh, Forrest W. Merica, Myron Metzenbaum, Theodore Miller, John B. Morgan, Bernard H. Nichols, Fred C. Oldenberg, L. E. Papurt, Clayton C. Perry, Lawrence A. Pomeroy, W. J. Quigley, Vernon C. Rowland, A. D. Ruedemann, Jack Arthur Rudolph, A. G. Schlink, H. A. Schlink, R. W. Scott, George D. Shaaber, Thomas P. Shupe, A. J. Skeel, Harry G. Sloan, Harry Sneiderman, S. A. Sobul, John A. Sommer, Tom Spies, A. B. Spurney, Robert M. Stecher, Richard E. Stifel, C. W. Stone, Abraham Strauss, John A. Toomey, Samuel J. Webster, Benjamin J. Wolpaw, Anna M. Young, N. L. Zinner.

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YOUNGSTOWN—M. H. Bachman, Edgar C. Baker, O. D. Brungard, Armin Elsaesser, H. E. Fusselman, John E. L. Keys, John S. Lewis, David E. Montgomery, M. W. Neidus, Wm. M. Skipp, S. J. Tamarkin, O. J. Walker, Herman S. Zeve.

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J. H. Caldwell, Warren; Benjamin Carlson, Lorain; Paul C. Colegrove, Oberlin; Robert Conard, Wilmington; George W. Cooper, Clarksburg; William W. Corwin, Beach City; Charles C. Deamude, Waterford; F. J. Dineen, Painesville; James K. Durling, Wadsworth; William P. Ellis, Painesville; Bert J. Ferciot, East Canton; John W. Franklin, Chillicothe; W. R. Galbreath, Wooster; D. F. Gerber, Middletown; H. P. Gillespie, Woodsfield.

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Cuskey, Senecaville; M. D. McCutcheon, East Liverpool; W. G. McDade, East Liverpool; Eugene H. Merrell, Geneva; H. C. Messenger, Xenia; Gilbert Micklethwaite, Portsmouth; J. F. Miller, Steubenville; Neil Millikin, Hamilton; R. V. Myers, Mansfield; M. E. Nichols, Lancaster; Lloyd M. Otis, Celina; C. S. Palmer, Massillon; Stephen J. Podlewski, Steubenville; E. H. Porter, Tiffin; M. H. Rosenblum, Steubenville; Herman S. Rhu, Marion; J. B. Sampsell, Van Wert; Walter C. Scheidt, Celina; Stanley C. Schiller, Mansfield; J. W. Schoolnic, East Liverpool; A. C. Siddall, Oberlin; Charles D. Slagle, Centerville; Alonzo C. Smith, Wooster; Jack F. Smyth, Salem; Otto P. Ulrich, Orrville; Graydon D. Underwood, Navarre; Charles S. Vidt, Ironton; George F. Van Pelt, Gordon; George N. Wenger, Massillon; S. C. Yinger, Sidney; J. P. Young, Empire.

UNIFORM NARCOTIC DRUG ACT AMONG IMPORTANT PIECES OF LEGISLATION ENACTED BY 91ST GENERAL ASSEMBLY; SEVERAL SPECIAL SESSIONS ARE ANTICIPATED

A MINIMUM of public health and medical legislation was enacted by the 91st General Assembly at its regular session which terminated on June 4.

No cult and anti-medical bills were passed by either house of the General Assembly.

It is anticipated that the Legislature will be called into special session at least once, and perhaps several times, during the next 18 months.

The first special session will be held in the Fall when important taxation matters will be considered. Among proposals which may be acted upon at that time are an income tax, a gross receipts tax, and a measure extending the present retails sales tax, with amendments to make it apply to *professional and non-professional services* which would include *medical*, dental, nursing, legal services, etc.

In all probability, the Legislature will be asked to consider a social insurance program at its special session in the Fall or at a second special session. This undoubtedly will include proposals for the establishment of unemployment insurance and enlarging the scope of the old age pension law; and possibly creating some system of *compulsory state health insurance.*

A session, or part of a session, devoted to consideration of proposed legislation on workmen's compensation is anticipated. Few measures on this question were enacted at the regular session although a large number, most of them highly controversial, were on the calendars of both the Senate and the House when the session ended. Recommendations for changing the Workmen's Compensation Law and modifying the administrative procedure are expected in the forthcoming reports of the Sherrill Commission on Reorganization of the State Government and the special Senate Workmen's Compensation Investigating Committee.

Uniform Narcotic Drug Act Enacted

One measure enacted at the regular session which is of special interest and importance to the medical profession is the Uniform Narcotic Drug Act, signed by the Governor on June 4 and effective September 5, 1935.

This act is in most respects identical with the model Uniform Narcotic Drug Act formulated by the National Conference of Commissioners on Uniform State Laws and strongly endorsed by the American Medical Association, the American Bar Association, the National Federation of Women's Clubs, and other outstanding national groups.

The measure, introduced by Representative Fred Mourey of Summit County, repeals the old Ohio statutes governing the prescribing, dispensing, administration and sale of narcotic drugs and brings state control of narcotic drugs into conformity with the Harrison (Federal) Narcotic Act. The act does *not* impose greater restrictions on physicians, dentists, pharmacists, etc., than the Harrison Act but provides state and federal enforcement officers with additional weapons to be used in combating the illicit traffic in narcotics.

A physician under the new Ohio act is not required to keep any records in addition to those he is already required to keep under the provisions of the Harrison Act and the regulations issued pursuant thereto.

Enforcement of the act is delegated to the State Board of Pharmacy. The previous Ohio narcotic statutes had been administered by the Division of Foods and Dairies, State Department of Agriculture.

MAJOR PROVISIONS SUMMARIZED

Major provisions of the new act are as follows:

Definitions—Section 1 gives the meaning of words and phrases used in the act. It defines "narcotic drugs" as coca leaves, opium, cannabis and every substance not chemically distinguishable from them and summarizes the compounds included in the above named drugs.

Acts Prohibited—Section 2 makes it unlawful to manufacture, possess, sell, prescribe, administer, dispense or compound any narcotic drug except as authorized in the act. It prohibits the cultivation, growing or processing of opium, coca leaves, cannabis or other narcotic drug without a license to do so from the State Board of Pharmacy, such license to cost $5.00. No license is required by physicians, dentists, veterinarians and

apothecaries. Section 3 gives the Board of Pharmacy broad powers governing the issuance of the manufacturers' license and revocation of the same.

Sale on Written Orders—Section 4 permits a duly licensed manufacturer or wholesaler to sell and dispense narcotic drugs on official written orders to a manufacturer, wholesaler or apothecary; a physician, dentist or veterinarian; a person in charge of a hospital for use by or in the hospital, providing the written order is signed by a physician, dentist, veterinarian or apothecary connected with the hospital; to a person in charge of a laboratory for use in the laboratory for scientific and clinical purposes; to a person possessing a certificate of exemption as required by the Federal Narcotic Law, who is in the employ of the United States government or any state, territorial, district, county, municipal or insular government and who is purchasing or receiving drugs by reason of his official duties; to a master of a ship or person in charge of any aircraft upon which no physician is regularly employed, for medical purposes, providing he possesses a special order form approved by a commissioned medical officer or acting assistant surgeon of the U. S. Public Health Service; and to a person in a foreign country if the provisions of the Federal Narcotic Law are complied with.

Official written orders must be signed in duplicate and copies must be preserved for two years. Compliance with the order form requirements of the Federal Narcotic Law is deemed compliance with the foregoing provisions.

Sale by Apothecaries—Section 5 provides that an apothecary in good faith may sell and dispense narcotic drugs upon written prescription of a physician, dentist or veterinarian, provided it is properly executed, dated and signed by the person prescribing and bears the full name and address of the patient or animal and the name, address and Federal registry number of the person prescribing. Prescriptions must be kept on file for two years and shall not be refilled. An apothecary also upon an official written order may sell to a physician, dentist or veterinarian, in quantities not exceeding one ounce at any one time, aqueous or oleaginous solutions of which the content of narcotic drugs does not exceed a proportion greater than 20 per cent of the complete solution, to be used for medicinal purposes.

Professional Use of Narcotic Drugs—Section 6 provides that a physician or dentist, in good faith and in the course of his professional practice only, may prescribe, on written prescription, administer, or dispense narcotic drugs, or he may cause the same to be administered by a nurse or intern under his direction and supervision. A similar provision is set up for veterinarians and their assistants or orderlies. Persons who have obtained from a physician or dentist narcotic drugs for administration to a patient during the absence of such physician or dentist must return to him any unused portion of such drugs when no longer required by the patient.

EXEMPTIONS ARE ESTABLISHED

Exempted Preparations—Section 7 sets up certain exemptions to provisions of the act as follows:

1. Where a physician, dentist or veterinarian administers or dispenses; or where an apothecary sells at retail any medicinal preparation that contains in one fluid ounce, or if a solid or semi-solid preparation, in one avoirdupois ounce, (a) not more than two grains of opium, (b) not more than one-quarter of a grain of morphine or of any of its salts, (c) not more than one grain of codeine or of any of its salts, (d) not more than one-eighth of a grain of heroin or any of its salts, (e) not more than one-half of a grain of extract of cannabis nor more than one-half of a grain of any more potent derivative or preparation of cannabis.

2. Where a physician, dentist or veterinarian administers or dispenses; or where an apothecary sells at retail liniments, ointments, and other preparations, that are susceptible of external use only and that contain narcotic drugs in such combination as prevent their being readily extracted, except that the act shall apply to all liniments, ointments, etc., that contain coca leaves in any quantity or combination.

The foregoing exemptions, however, are subjected to the following conditions and restrictions:

1. No person may prescribe, dispense, administer or sell to any one person or for the use of any one person, any of the exempted preparations when he knows or can by reasonable diligence ascertain that such prescribing, dispensing, etc., will provide the person within any 48 consecutive hours with more than four grains of opium, or more than one-half grain of morphine or any of its salts, or more than two grains of codeine or any of its salts, or more than one-quarter of a grain of heroin or any of its salts, or will provide such person within 48 consecutive hours with more than one exempted preparation.

2. The medicinal preparation or the liniment, ointment, etc., shall contain, in addition to the narcotic drug in it, some drug or drugs conferring upon it medicinal qualities other than those possessed by the narcotic drug alone.

3. Nothing in the section shall be construed to limit the kind and quantity of any narcotic drug that may be prescribed, administered, dispensed or sold, to any person or for the use of any person or animal, when it is prescribed, administered, compounded, dispensed or sold in compliance with the general provisions of the act.

KEEPING OF RECORDS

Records to be Kept—Section 8 pertains to the keeping of records. It requires a physician, den-

tist, veterinarian, etc., to keep a record of narcotic drugs received by him and a record of all such drugs administered, dispensed or professionally used by him, otherwise than by prescription, when the amount administered, dispensed or professionally used in the treatment of any one person exceeds in any 48 consecutive hours: (a) four grains of opium, or (b) one-half grain of morphine or its salts; (c) two grains of codeine or its salts; (d) or one-fourth of a grain of heroin or its salts; or (e) a quantity of any other narcotic drug or any combinations of narcotic drugs that exceed in pharmacologic potency any one of the foregoing drugs in the quantity stated. *This means that a physician does not have to keep a record of narcotic drugs administered, dispensed or professionally used when the amount for any one person does not exceed in any 48 consecutive hours the above stated quantities.*

A physician or dentist using small quantities of solutions or preparations of narcotic drugs for local application need not keep a record of the amount of each solution or preparation applied by him to individual patients if he keeps a record of the quantity, character and potency of such solutions or preparations purchased or made up by him.

Manufacturers, wholesalers and apothecaries and persons who purchase for resale or who sell exempted narcotic drug preparations, need not keep records of narcotic drugs received or disposed of by them in addition to records required by or under the Federal Narcotic Law.

Labels, Containers, etc.—Sections 9, 10, 11 and 12 contain provisions of no particular interest to physicians.

Disposition of Seized Narcotic Drugs—Section 13 provides that narcotic drugs seized by enforcement officers, the lawful possession or title of which cannot be established, may be destroyed; on request, may be delivered to the State Department of Health for distribution or destruction; or may be delivered by the State Department of Health to charitable hospitals.

REVOCATION OF LICENSES

Conviction and Revocation of Licenses—Section 14 provides that on the conviction of a physician, dentist, veterinarian or pharmacist of the violation of any provisions of the act, notice of such conviction and pertinent documents shall be sent to the board by whom the convicted defendant has been licensed or registered, and such board shall have the power to revoke such license or registration.

This section also provides that any physician, dentist, veterinarian or apothecary who is or shall become addicted to the drug habit, shall have his license or registration suspended by his respective licensing board until such time as he shall offer satisfactory proof to the board of having become cured of such habit. Upon any relapse from such cure the license shall become permanently revoked.

Records Confidential—Section 15 provides that prescriptions, orders and records shall be open to inspection of proper enforcement officers but that they shall keep such information confidential except in connection with prosecutions or revocation proceedings.

WEAPONS AGAINST ADDICTS, ETC.

Fraud and Deceit—Section 16 is one of the important sections of the act and provides federal and state enforcement officers with the authority to arrest addicts, raid dope dens, etc. Its provisions are as follows:

1. No person shall obtain or attempt to obtain a narcotic drug, or procure or attempt to procure the administration of a narcotic drug by fraud, deceit, misrepresentation, or subterfuge; or by the forgery or alteration of a prescription or written order; or by the concealment of a material fact; or by the use of a false name or the giving of a false address.

2. Information communicated to a physician or dentist in an effort unlawfully to procure a narcotic drug, or unlawfully to procure the administration of any such drug, shall not be deemed a privileged communication.

3. No person shall wilfully make a false statement in any prescription, order, report or record required by the act.

4. No person shall, for the purpose of obtaining a narcotic drug, falsely assume the title of, or represent himself to be, a manufacturer, wholesaler, apothecary, physician, dentist, veterinarian, or other authorized person.

5. No person shall make or utter any false or forged prescription or written order.

6. No person shall affix any false or forged label to a package or receptacle containing narcotic drugs.

7. No person except a manufacturer or wholesaler or a retail dealer in surgical instruments, apothecary, physician, dentist, veterinarian, nurse or intern shall at any time have or possess a hypodermic syringe or needle or any instrument or implement adapted for the use of habit forming drugs by subcutaneous injection and which if possessed for the purpose of administering habit forming drugs, unless such possession be authorized by the certificate of a physician issued within the period of one year prior thereto.

Complaints, Indictments, etc.—Section 17 provides that the burden of proof of exceptions and exemptions is on the defendant; that rooms or places where the provisions of the act are believed to be violated may be entered and searched; that those hindering, obstructing or interfering with the enforcement of the act shall be guilty of

a misdemeanor and that arrests may be made without warrant.

Enforcement and Cooperation — Section 18 places enforcement of the act in the hands of the State Board of Pharmacy, all officers within the state and prosecuting attorneys, and makes it a duty for them to cooperate with Federal narcotic enforcement officers.

Penalties—Section 19 provides the following penalties: Conviction on first offense, fine not exceeding $500 or imprisonment for not exceeding five years or both; any subsequent offense, fine not exceeding $1000 or imprisonment not exceeding five years, or both.

Medical Benefits for Relief Employes

A system to provide compensation, death benefits, and the payment of medical, nurse and hospital services, medicine and funeral expenses for public work-relief employes who are injured, and the dependents of such as are killed, in the course of their employment is provided through enactment of an emergency measure introduced by Miss Ruth Lloyd, representative of Scioto County, which was signed by the Governor and became effective May 20.

The act provides that work relief employes shall be eligible to the benefits of the Ohio Workmen's Compensation Act except as otherwise specified in the Lloyd Act.

It defines "work relief employe" as any person engaged in any public relief employment and receiving "work relief", who is under the supervision and control of any employer mentioned in the act or any agency of such employer.

"Work relief" is defined as public relief given in the form of public funds or goods, on the basis of budgetary needs of the work-relief employe and his dependents, in exchange for any service or labor rendered on or in connection with any public relief employment.

An "employer" as defined by the act is the state or the State Relief Commission or any other state agency having supervision or control of work-relief employes, either directly or through agencies; each county, city, township, incorporated village and school district.

The State Industrial Commission is given the authority to levy and collect premiums from work-relief employers on a basis to be determined by the Commission. Such premiums must be segregated by the Commission in what is known as the "Public Work-Relief Employes' Compensation Fund" from which compensation, death benefits and medical, nursing, hospital and funeral expenses are to be paid.

WORKMEN'S COMPENSATION STATUTES FOLLOWED

The medical, nursing, hospital and funeral expenses of a work-relief employe injured or killed in the course of and arising out of employment will be paid out of the above fund in accordance with the provisions of the Workmen's Compensation Act.

Compensation and death benefits are provided for in the following manner:

During the periods of temporary disability and partial disability other than that resulting from loss of member or sight or total or partial loss of use of member, the injured work-relief employe will be paid directly out of the fund or funds from which said employe was receiving relief (i.e., the relief funds of the political subdivision), such amounts as are required to meet the budgetary needs of such employe and his dependents, and in such manner as shall be determined by the work-relief employer.

When all of the funds for relief purposes available to any work-relief employer are exhausted or when disability as a result of the injury is continuous beyond a period of six months, the injured employe shall be compensated for temporary and partial disability out of the Public Work-Relief Employes' Compensation Fund by the Industrial Commission.

In case of loss of specific members or sight as set forth in the regular schedule of the Industrial Commission, compensation will be paid in accordance with definite computations.

The basis upon which compensation is computed is the amount of work-relief which would have been afforded the injured employe for the calendar week in which the injury or death occurred, not to exceed in any event $18.75 per week.

Claims filed under the act are barred unless application is made within 60 days after the injury or death, except that in cases occurring prior to the date on which the act became operative, application may be made within 60 days after such date.

Notice of injury or death must be filed with the employer within five days thereafter on forms supplied by the Industrial Commission.

The decision of the Commission on all questions of fact are final. However, its decisions on questions of law are appealable.

Sections of the Workmen's Compensation Act relating to occupational diseases, expected increase in wages, lump sum payments, and right of appeal, are not applicable to the Lloyd Act.

The act provides coverage for all persons now engaged on work-relief projects being carried on by the state or local subdivisions.

Miscellaneous Measures Enacted

Among other measures enacted were:

The Carey bill making it mandatory that public health nurses in city health districts be registered nurses.

The Campbell bill to permit probate or juvenile courts to provide temporary medical and surgical

treatment of court wards pending disposition of their cases.

The McIntyre bill to provide for reimbursement by the state of counties for expenses incurred from housing in detention hospitals persons subsequently adjudged insane and committed to a state hospital.

The Rogers bill appropriating $500,000 for construction and repairs at state welfare institutions.

A bill authorizing counties to issue poor relief bonds and designating county commissioners to head county poor relief activities, with the right to delegate such functions to the Federal Government.

LARGE CLASS OF APPLICANTS TAKE EXAMINATIONS BEFORE STATE MEDICAL BOARD, JUNE 4-7; LIST OF QUESTIONS ASKED

THREE hundred and forty applicants for licenses to practice medicine, surgery and the limited branches of medicine took the examinations given by the State Medical Board at Columbus June 4 to 7.

Those who took the examinations for licenses in medicine and surgery numbered 252; 84 of this number being graduates of the College of Medicine Ohio State University; 66 of the School of Medicine, Western Reserve University; 63 of the College of Medicine, University of Cincinnati; 16 of the Eclectic Medical College, Cincinnati, and 23 from medical schools of other states.

In addition, the following took examinations for licenses in their respective fields of practice: 21 osteopaths, 35 chiropodists, 9 chiropractors, 11 mechano-therapists, 6 masseurs, 5 cosmetic- therapists and one electro-therapist.

Results of the examinations will be announced and licenses awarded at the next meeting of the Board, July 9.

The written examinations were conducted at the New Gymnasium, Ohio State Univeristy and the practical examinations at St. Francis Hospital.

Questions asked the medical and surgical applicants in the written examinations follow:

ANATOMY

1. Locate the hyoid bone.
Name the surfaces and borders and give the muscles attached to it.
2. Give the beginning of the inferior ophthalmic vein. What does it drain? How and where does it end?
3. What is the origin of the dorsalis pedis artery? Where does it divide? Name the branches.
4. Where does the obturator internus muscle arise? Give the insertion, action and nerve supply.
5. Name the largest cranial nerve.
Mention the main divisions and name the branches of the first division.

PHYSIOLOGY

1. What is the function of the reticulo-endothelial system?
2. Upon what factors does the efficiency of the heart depend? Distinguish cardiac muscle from skeletal and involuntary muscles in structure and function. What are its five properties?
3. What is the primary disturbance in shock? What are its principal causes? How is it combated?
4. Distinguish five common irregularities of the pulse.
5. How would you diagnose auricular fibrillation without mechanical aids? What is the pulse deficit?
6. What is the relation of the vital capacity to dyspnea and circulatory deficiency?
7. Draw a section of the thoracic cord, showing the principal ascending and descending tracts.
8. Distinguish between reflex changes due to lesions of the motor cortex or the pyramidal tract and those due to lesions of the anterior horn cells.
9. Give the function of the cerebellum. Describe the general formation of the autonomic nervous system and give its functions.
10. Describe the optic tract. What is the fovea centralis; the macula lutea; what is the function of the rods and cones?

DIAGNOSIS

1. Differentiate between polyneuritis caused by lead and that by arsenical poisoning.
2. Give etiology of inguinal lympho-adenitis.
3. A woman brought to the hospital in a condition of coma—how would you proceed to make a diagnosis?
4. Discuss bronchial asthma in relation to allergic causes.
5. Give etiology and diagnosis of acute osteomyelitis of femur.
6. Differentiate between acute pancreatitis and ruptured stomach ulcer.
7. What signs and symptoms would lead you to a diagnosis of Hodgskin's disease?
8. What findings would lead you to suspect a tumor of the spinal cord at the seventh dorsal vertebrae?
9. Differentiate between diphtheria and septic sore throat.
10. Differentiate between an acute and chronic abscess of the left parietal lobes of the brain.

CHEMISTRY

1. (a) Define a carbohydrate and a hydrocarbon. Give an example of each.
(b) Name enzymes that digest carbohydrates.
2. Name five vitamins; where found, and what conditions are caused by their deficiency.
3. (a) What three things are determined by chemical analysis of gastric contents?
(b) Give qualitative and quantitative test for free hydrochloric acid in gastric contents.
4. Define metabolism. What is the normal metabolic rate (basal)?
5. (a) In what condition do you find diacetic acid (aceto-acetic) in urine?
(b) Give test for presence in urine.

MATERIA MEDICA (Eclectic)

1. Discuss lobelia and ipecac. Give dosage, effects and indication of each.
2. What are the indications and dosage of aconite?
3. Discuss the indications and dosage of potassium iodide.
4. What are the standard preparations of belladonna and their dosage? Indication?
5. What is an astringent? Give two examples and indications for same.
6. Give indications for the following drugs:
(a) veratrum (b) gelsemium (c) byromnia
7. Give oral and hypodermic dosage of:
(a) morphine sulphate (b) codeine sulphate.
8. Discuss indication and dosage of insulin.
9. Discuss respiratory sedatives. Name examples and usual dosage.
10. Give indications and dosage of thyroid extract. What would be your indications for its discontinuance?

MATERIA MEDICA AND THERAPEUTICS

1. List remedies you would use in the treatment of influenza, giving dose of each.
2. Give the physiological action and therapeutic uses of tincture of belladonna, with dosage.
3. Hydrargyri Chloridum Mite—list its therapeutic uses.
4. What remedies are recommended in the treatment of anorexia?
5. Give action, uses and dose of quinine sulphate.
6. Discuss the physiological action and therapeutic uses of strophanthus.
7. Name the preparations of opium. Which are in common use? State the amount of each which represents one grain of opium.
8. From what source is salicin derived and what is its dose and physiologic action?

9. List the untoward effects sometimes encountered when digitalis is used.
10. What remedies would you employ in the treatment of spasmodic croup? Give dose.

BACTERIOLOGY, PATHOLOGY AND HYGIENE

1. Give method of obtaining spinal fluid for diagnosis. Name three micro-organisms causing meningitis and how distinguish them.
2. What is meant by agglutination of bacteria and what use is made of this phenomenon in diagnosis?
3. Name two pathogenic organisms that may be transmitted to man from animals, and discuss method of transmission.
4. Discuss the difference in pathology in—
(a) simple hypertrophy of prostate
(b) malignancy of prostate
5. Describe the pathology of an irregular enlargement of uterus associated with irregular hemorrhagic discharges.
6. Discuss the pathologic possibilities of a tumor of the breast.
7. Distinguish between the changes in the spinal cord in locomotor ataxia and in advanced pernicious anemia.
8. Name the more important diseases which should be reported to the local health officer.
9. Discuss your procedure in case of a patient bitten by a dog.
10. Discuss the reasons why meat inspection is necessary as a health measure.

PRACTICE

1. What is meant by a food deficiency disease? Name two, giving the deficient element and indicate treatment.
2. Give the symptoms and treatment of cardiac coronary thrombosis:
(a) during attack (b) subsequent treatment when patient survives initial attack.
3. Give the symptoms, diagnosis and treatment of bronchiectasis.
4. Give the medical treatment of gastric ulcer with indications when surgical treatment should be advised.
5. Outline the treatment of a case of scarlet fever in a home in which there are several non-immune children.
6. Discuss the treatment of a case of nephritis showing marked general edema.
7. Give the symptoms of hemorrhages of middle cerebral artery of moderate degree—
(a) immediate (b) subsequent developments.
8. Give the etiology of ascites and how distinguish it from tuberculous peritonitis.
9. Give the symptoms and prognosis of dementia praecox.
10. In what condition occur—
(a) delusions of grandeur (b) delusions of persecution (c) the hearing of voices or other sounds (d) visual monstrosities.

SURGERY

1. Give the indications for surgical treatment in pulmonary tuberculosis.
2. Differentiate between cephalocele, encephalocele and hydrencephalocele.
3. Differentiate between ileus and intestinal obstruction post operative.
4. Discuss the healing of fractures; name some of the factors causing non-union.
5. Discuss carcinoma of the breast; give treatment.
6. What indications would lead you to diagnose esophageal ulcer?
7. What laboratory work should be done preceding prostatectomy?
8. What is the effect of total thyroidectomy in angina pectoris?
9. Discuss intravenous drip.
10. Discuss acidosis and alkalosis from a surgical viewpoint.

OBSTETRICS
(answer any five)

1. Describe the proper treatment of a shoulder presentation.
2. Give indications for use of forceps, and give in detail the mode of application.
3. Describe some of the best substitutes for mother's milk, and give schedule for their use as to age, amount and number of feedings per day.
4. When justified in producing an abortion, what precautions should be taken; give the best procedure.
5. Give treatment for excessive vomiting in pregnancy.
6. Give in detail your procedure in treatment of postpartum hemorrhage.
7. Give the data on which at term a diagnosis of first position of the vertex (L.O.A.) may be made without making a vaginal examination.

SPECIALTIES

1. Name three hearing tests and tell how each is done.
2. Give in detail your management of a case of acute suppurative otitis media.
3. What, if any, is the relation of pathology of the visual tract to sinus disease?
4. Name three ways in which so-called "squint" may be corrected.
5. Diagnose and prescribe for a case of pemphigus neonatorum.

Annual Meeting of the Ohio Public Health Association Held At Columbus

About 200 attended the annual meeting of the Ohio Public Health Association held at the Neil House, Columbus, May 16 and 17.

Dr. J. H. J. Upham, Columbus, presided at the opening luncheon. The speakers were Dr. Kendall Emerson, New York City, on "Fighting Tuberculosis with Modern Weapons", and Dr. Charles A. Neal, Cincinnati, president of the Ohio Public Health Association, on "The Relation of the Unofficial Tuberculosis Organization to the Official Health Department and the Private Physician".

The Health Education Session was presided over by Dr. Kennon Dunham, Cincinnati, president, National Tuberculosis Association. Addresses were given by Hon. B. O. Skinner, Director of Education of the State of Ohio, on "The Relation between Health Education in the Schools of Ohio and the Prevention of Tuberculosis"; and L. B. Hindman, Executive Secretary, Lorain County Tuberculosis and Health Association, on "A County-Wide Tuberculosis Testing Program in Lorain County".

Dr. J. W. Wilce, Columbus, director, University Health Service, Ohio State University, presided over the Medical Session, which was addressed by Dr. Charles A. Doan, Columbus, member of the Department of Medical and Surgical Research, Ohio State University, on "The Use of Tuberculin as a Diagnostic Agent with Special Reference to Purified Protein Derivative"; and Dr. Warren C. Breidenbach, medical superintendent, Stillwater Sanatorium, Dayton, on "Practical Application of P. P. D. in a Series of Cases".

Dr. Frank C. Anderson, Mt. Vernon, president, Ohio Association of Sanatorium Superintendents, presided over the Sanatorium Section. Speakers were Dr. Myron D. Miller, Columbus, superintendent, Franklin County Sanatorium, on "Responsibility for Tuberculosis Hospital Provision Including Use of General Hospitals"; Dr. W. Miles Garrison, St. Clairsville, superintendent, Belmont County Sanatorium, on "Danger of Infection of Sanatorium Employees"; L. A. Boulay, State Engineer, Federal Public Works Administration, on "Program for New Construction and Additions to Sanatorium Facilities in Ohio".

Charles C. Stillman, Columbus, Federal Emergency Relief Administrator in Ohio, spoke on "The Health Program in Ohio Under Federal Appropriations", at the Friday luncheon, which was presided over by Dr. E. R. Hiatt, Troy, Health Commissioner of Miami County.

Dr. E. R. Hiatt, Troy, was elected president of the association; Dr. E. L. Brady, Marion, and Dr. E. B. Pierce, Canton, vice-presidents; Dr. C. A. Doan, Columbus, secretary; C. L. LaMonte, auditor; Attorney General John W. Bricker, counsel, and Thomas H. Dickson, treasurer.

NEWS NOTES *of* OHIO

Columbus—A foundation for the purchase and maintenance of a medical library is established by the will of the late Mrs. Jane Moore, Columbus, in memory of her son the late Dr. Edgar Howard Moore. The trustees of the foundation are Drs. F. F. Lawrence, Hervey W. Whitaker and William C. Davis, of Columbus. Literature purchased by the trustees, under the terms of the will, will be placed in an alcove in the Columbus Public Library.

Mansfield—Dr. John S. Hattery recently spoke before the Kiwanis Club on the subject of "Why We Live Longer".

Cleveland—Dr. Lawrence A. Pomeroy was elected treasurer of the American Radium Society at its recent convention in Atlantic City.

Coshocton—Dr. Edward M. Wright was elected president of the Ohio State Eclectic Medical Association at the convention of that organization recently held in Cincinnati. Coshocton was selected as the meeting place for the 1936 convention.

Athens—Another Sprague entered the medical profession with the graduation from the University of Cincinnati, College of Medicine, of John T. Sprague, son of Dr. John R. Sprague, Athens, nephew of Dr. Warren V. Sprague, Chauncey and Dr. Wylie T. Sprague, ship's surgeon on the Grace Liner, Santa Rita, plying between New York and Chile. Dr. Wylie Sprague's son, Dr. Gerald practices at Nan Nuyes, California, and Dr. Warren's son, Dr. Lindley, is on the faculty of the University of Wisconsin School of Medicine. Following completion of his interneship at University Hospital, Columbus. Dr. John T. Sprague will begin practice with his father at Athens.

Toledo—Dr. Frank B. Ficklin has been elected president of the Toledo Medical Study Club. Other officers are Dr. H. E. Bechtel, vice-president; Dr. Paul R. Badger, secretary, and Dr. George M. Hite, treasurer. Dr. Henry Price, retiring secretary, was presented with a surgical bag.

Cleveland—Dr. Myron Metzenbaum recently gave a clinical demonstration of "The Nasal Septum in Relation to Normal Jaw Development in Children" at the annual clinical meeting of the Cleveland Dental Society.

Elyria—A recent meeting of the American Legion Auxiliary was addressed by Drs. H. J. Austin, S. J. Birkbeck, G. D. Nicholas and A. W. Robishaw on the subject of "Pre-natal Care".

Cleveland—Dr. Alfred I. Ludlow, head of the surgical and research departments of Severance Union Medical College, Seoul, Korea, has returned to Cleveland for a year's furlough following seven years' absence from America.

Columbus—In one of the concluding addresses before the National Advisory Council on Radio in Education, which convened in Columbus recently, Dr. John H. J. Upham, Dean of the College of Medicine of Ohio State University, suggested a central body to publicize programs of a cultural nature as a means of awakening public interest.

Columbus—Dr. Emery R. Hayhurst, Columbus, for 17 years Associate Editor in Industrial Hygiene of the *American Journal of Public Health* has resigned.

Bellefontaine—The office of Dr. O. C. Amstutz was damaged by fire when an electric sterilizer burned dry and short-circuited.

Cincinnati—Dr. A. C. Bachmeyer, former dean of the University of Cincinnati College of Medicine, now connected with the University of Chicago, received the honorary degree of doctor of science from the University of Cincinnati at the recent commencement exercises.

Bellefontaine—Dr. Charles L. Barrett addressed the Kiwanis Club at Hotel Logan.

Cardington—Dr. Florence Smith-White Goodhue has retired after practicing for 51 years.

Middletown—Dr. W. A. Whitman, who served as prison physician at the Ohio Penitentiary for 20 years, addressed the Rotary Club on "Capital Punishment".

Ironton—Dr. Anne D. Marting was elected president of the Ohio Business and Professional Women's Club at the annual convention of that organization held in Cincinnati recently.

Garrettsville—Dr. C. C. Roller, formerly of Youngstown, has opened offices here.

Alliance—Dr. George M. Wilcoxon will open offices here, and will also be head football coach at the local high school.

Cincinnati—Dr. Carl A. Wilzbach, Executive Secretary of the Cincinnati Social Hygiene Society, recently addressed the Public Affairs Forum of the Y. W. C. A., on "Socialized Medicine". Dr. Wilzbach is a member of the committee of the Academy of Medicine which has made a study of socialized medicine.

Garrettsville—Dr. Myron W. Thomas has established offices here.

Niles—Dr. J. M. Gledhill has opened offices here.

DEATHS IN OHIO

Oscar H. Adamson, M.D., Georgetown; Cleveland College of Medicine and Surgery, 1889; aged 70; died June 3 after a long illness. Dr. Adamson began the practice of medicine in Mason county, Kentucky, moving to Georgetown in 1918, where he practiced until compelled to retire because of ill health a few months ago. He was health director for Brown County for ten years. He was a member of the Christian Church and the Masonic Lodge. He is survived by a daughter.

Karl Walter Allison, M.D., Youngstown; College of Physicians and Surgeons of Baltimore, Md., 1911; aged 52; member of the Ohio State Medical Association and Fellow of the American Medical Association; died May 22 of an embolism of the brain. Dr. Allison had practiced in Youngstown since 1910. At the time of his death he was chief of the proctological service at North Side Hospital. He was active in the Masonic and I. O. O. F lodges. Surviving are his wife, two daughters, two sisters and one brother.

Carl W. Ampt, M.D., Cleveland; Berlin University, Germany, 1895; aged 64; died May 21 after an illness of six weeks. Dr. Ampt practiced on the West Side of Cleveland for 38 years. He is survived by his widow.

Orville L. Baldwin, M.D., Columbus; Rush Medical College, University of Chicago, 1922; aged 42; member of the Ohio State Medical Association, Fellow of the American Medical Association, and member of the American Academy of Pediatrists; died June 9, from a heart attack. A native of Cridersville, Dr. Baldwin practiced in Columbus for 12 years, specializing in pediatrics. He was a member of the staffs of Grant, White Cross, St. Ann's and Children's hospitals. Surviving are his widow, his mother and a sister.

Eldorado C. Briggs, M.D., Wilmington; Medical College of Ohio, Cincinnati, 1881; aged 82; member of the Ohio State Medical Association and Fellow of the American Medical Association; died May 27 of heart disease. Dr. Briggs practiced in Wilmington for 46 years. He was a member of the Masonic Lodge and the Modern Woodmen of America. He is survived by one brother.

William T. Cooke, M.D., Toledo; St. Louis University School of Medicine, St. Louis, Mo., 1933; aged 27; died May 19, after a week's illness. Dr. Cooke was resident physician at St. Vincent's Hospital. Surviving are his parents.

Matthias M. Corwin, M.D., Ansonia; Starling Medical College, Columbus, 1897; aged 66; former member of the Ohio State Medical Association; died June 4, after an extended illness. Dr. Corwin had been in active practice for 37 years at Savona and Ansonia. He was a member of the Masonic Lodge. Surviving are his widow, one son—Dr. Robert F. Corwin, Dayton, two brothers and three sisters.

Louise Eastman, M.D., Cincinnati; Eclectic Medical College, Cincinnati, 1898; aged 77; died June 8. Dr. Eastman practiced in Cincinnati many years, retiring ten years ago. She is survived by two sons.

George B. Haggart, M.D., Alliance; Cleveland University of Medicine and Surgery, Cleveland, Ohio, 1892; aged 66; member of the Ohio State Medical Association and Fellow of the American Medical Association; died May 10, following a cerebral hemorrhage. Dr. Haggart practiced in Alliance for 40 years. He was a member of the First Methodist Episcopal Church. He is survived by his widow and one sister.

Louis D. Hamilton, M.D., Marion; Columbus Medical College, Columbus, 1881; aged 79; former member of the Ohio State Medical Association and the American Medical Association; died May 26. Dr. Hamilton practiced six years in Ostrander and 44 years in Marion, before retiring four years ago. He was a member of the Masonic Lodge, the Knights of Pythias and the First Presbyterian Church. Surviving are his widow, five sons, three daughters, one sister and two brothers.

William Holland Henderson, M.D., Portsmouth; University of Cincinnati, College of Medicine, Cincinnati, Ohio, 1928; aged 32; former member of the Ohio State Medical Association and the American Medical Association; died May 14, following a heart attack. Dr. Henderson was assistant physician for the Selby Shoe Comapny. Surviving are his widow, three sons, his mother and a brother.

Ira J. Herr, M.D., Dayton; Pulte Medical College, Cincinnati, 1894; aged 68; died June 7. Dr. Herr had practiced in Dayton for 42 years. He was a member of the Masonic Lodge. He is survived by a sister and a brother.

John P. Kenny, M.D., Youngstown; University of Pittsburgh, School of Medicine, 1896; aged 62; died May 17. Dr. Kenny practiced in Youngstown for 38 years, and had been police physician since September, 1931. He is survived by his widow and three sons.

Alexander McGregor, M.D., Springfield; Columbus Medical College, Columbus, Ohio, 1892; aged 83; former member of the Ohio State Medical Association and the American Medical Association; died May 27, following a long illness. Dr. McGregor practiced in Springfield until his re-

tirement 4 years ago because of failing eyesight. He was a member of the Masonic Order. Surviving are his widow, a daughter and a brother.

Samuel Lawrence McManigal, M.D., Garrettsville; Medical College of Ohio, Cincinnati, 1902; aged 60; member of the Ohio State Medical Association and Fellow of the American Medical Association; died at St. Luke's Hospital, Cleveland, June 6, after a long illness. Dr. McManigal had been a member of the Portage County Medical Society since 1917.

William Valentine Mullin, M.D., Cleveland; Denver and Gross College of Medicine, 1908; aged 51; member of the Ohio State Medical Association and Fellow of the American Medical Association and Fellow of American College of Surgeons; died April 25, from cavernous sinus thrombosis of unknown origin. Dr. Mullin engaged in general practice in Colorado until 1910. In 1926 he became head of the otolaryngological division of the Cleveland Clinic. He was a member of the American Otological Association, the American Laryngological Rhinological and Otological Association, the Association for the Study of Allergy and the American Medical Editors and Authors Association. During the World War he was a lieutenant in the Medical Corps of the U. S. Army. Surviving are his widow and a daughter.

Harry M. O'Brien, M.D., Cleveland; St. Louis University School of Medicine, St. Louis, Mo., 1918; aged 44; died May 15. Dr. O'Brien was forced to retire three years ago due to ill health. During the World War he was stationed with the Medical Corps at Paris Island. He is survived by his widow, three daughters, a son and two sisters.

Salmen K. Siebler, M.D., Cincinnati; University of Cincinnati, College of Medicine, 1918; aged 41; member of the Ohio State Medical Association, Associated Anaesthetists of the United States and Canada, and Fellow of the American Medical Association; died June 9, after a year's illness. Dr. Siebler was pediatrician at Jewish Hospital, attending clinician in pediatrics at General Hospital and at the Child Guidance Home, and formerly medical director of the United Jewish Social Agencies. He was a member of the Masonic Lodge. Surviving are his mother, two brothers and four sisters.

Norval C. Vaughn, M.D., Cincinnati; Howard University College of Medicine, Washington, D. C., 1896; aged 67; died April 20, following a heart attack.

John W. Wright, M.D., Columbus; Cincinnati College of Medicine and Surgery, Cincinnati, Ohio, 1873; aged 93; member of the Ohio State Medical Association, the American Academy of Ophthalmology and Otolaryngology, and the American Medical Association; died May 23. Dr. Wright was professor of ophthalmology at Ohio Medical University and at Starling-Ohio Medical College, and later professor emeritus in the College of Medicine, Ohio State University. He was credited with having devised the original technique for an operation for cataract. He started practice in Port Washington in 1865, continuing in Ragersville and Coshocton until 1880, when he moved to Columbus, practicing there until his retirement two years ago. He was a member of the Masonic Lodge. Surviving are two daughters, a son, a brother and a sister.

KNOWN IN OHIO

Abraham David Murphy, M.D., New York, Miami Medical College, Cincinnati, 1887; aged 72; died June 2, of heart disease. Dr. Murphy retired in 1925 after practicing in Cincinnati for many years. He is survived by his widow and a daughter.

James A. Monroe, M.D., Wheeling, W. Va.; Eclectic Medical College, Cincinnati, 1882; aged 92; died suddenly from a heart attack, May 30; Dr. Monroe practiced in Urbana, Ohio, for several years before moving to Wheeling, W. Va. He retired in 1920. He was prominent in the First Christian Church. Surviving are his widow, one son, two daughters, one brother and a sister.

Bartlett K. Menefee, M.D., Covington, Ky.; Louisville Medical College, Kentucky, 1893; aged 71; member of the Kentucky Medical Association and the American Medical Association; died May 20, from a self-inflicted bullet wound. Dr. Menefee was widely known in Northern Kentucky. Surviving are his widow, two daughters and a brother.

Harry E. Oesterling, M.D., Wheeling, W. Va.; University of Pennsylvania School of Medicine, Philadelphia, 1897; aged 62; member of the American Academy of Ophthalmology, the American College of Surgeons and Fellow of the American Medical Association; died May 21, at Philadelphia. Dr. Oesterling began practice in Wheeling in 1904. During the World War, he was a captain in the Medical Corps of the U. S. Army, stationed at the base hospital at Camp Lee, Va. He retired recently and had been living at Winter Park, Florida. Dr. Oesterling was a member of the Masonic Lodge and B. P. O. Elks. He is survived by his widow.

Clifton Brooks Willmott, M.D., Louisville, Ky.; Louisville Medical College, Louisville, Ky., 1904; aged 56; member of Kentucky Medical Association and Fellow of the American Medical Association; died May 18, following an illness of two weeks. Dr. Willmott practiced in Lexington, Ky., prior to becoming associate clinical professor of dermatology and syphilology, University of Louisville School of Medicine, Louisville, Ky. He was in the Medical Corps of the U. S. Army, serving overseas as surgeon in the 72nd New York regiment. Surviving are his widow and a brother.

Industrial Accident Congress

The Seventh International Congress on Industrial Accidents and Diseases will be held at Brussels, Belgium. The American Committee of the Congress is under the chairmanship of Dr. Fred H. Albee, New York, for the Section on Accidents, and that of Dr. Emery R. Hayhurst, Columbus, for Industrial Diseases. The American delegation to the Congress will sail from New York on July 8 and visit London, Amsterdam, The Hague and Paris, and, optionally, Budapest. Physicians interested in the Congress or in the medical tour in conjunction with it, may address the secretary, Dr. Richard Kovacs, 1100 Park Avenue, New York City.

—OSMJ—

New York Graduate Fortnight

The Eighth Annual Graduate Fortnight of The New York Academy of Medicine will be held October 21 to November 2 and will be devoted to a consideration of diseases of the respiratory tract. Eighteen hospitals of the city will present coordinated afternoon clinics and clinical demonstrations. At the evening meetings prominent clinicians from various parts of the country, who are recognized authorities in their fields, will discuss various aspects of the general subject. A comprehensive exhibit of books and of anatomical, bacteriological and pathological specimens and research material will be assembled. Demonstrations will be held at regular intervals.

Senior Prizes Awarded

School of Medicine, Western Reserve University, has announced awards of two annual prizes. The senior prize in surgery went to Carl Bernard Lechner of Erie, Pennsylvania, who entered the School of Medicine from Villanova College. This prize consists of books and surgical papers of the late Professor William Steward Halsted of Johns Hopkins University, and is the annual gift of Dr. Elliot C. Cutler, formerly professor of surgery of the School of Medicine, now of Harvard University. The senior prize in obstetrics was awarded to Edwin Alonzo Lawrence, Norwalk, Ohio, who has his A.B. from Oberlin College. This prize is the income from the fund given by Dr. Edwin C. Garvin, a graduate of the School of Medicine in 1894.

CLASSIFIED ADVERTISEMENTS

Rates for advertisements under this heading are 50 cents per line, payable in advance. Minimum charge of $1.00 for each insertion. Price covers the cost of remailing answers. Forms close 16th of the month preceding publication.

Wanted—Young physician to locate in Ohio county seat town of 2500 population. Excellent opportunity for young practitioner. Address C. W. J., care **Ohio State Medical Journal.**

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VITAMIN STABILITY DURING CANNING

● For over twenty years, intensive studies have been made of the stabilities of the vitamins under various conditions and treatments. Data accumulated indicate that certain vitamins contained in foods may, under specific conditions, be sensitive to oxygen in the presence of heat, or to heat or oxygen alone (1).

Broad details concerning vitamin stabilities are now general knowledge. The basic principle of commercial canning, namely heat sterilization of foods in sealed containers, is also generally known. As a consequence, there has been a tendency in some quarters to regard canned foods as deficient in certain, if not all, vitamins originally present in the raw material because of the conditions to which they were subjected during the canning procedures. Such a concept is not consistent with the established facts.

In future issues it is our intention to review the vitamin values of specific canned foods, as well as other nutritional virtues which they may possess. At this time we should like briefly to survey the matter of the stability of the most widely distributed vitamins during the canning procedure:

In general, vitamin A is not affected by commercial canning. This also appears true of vitamin G, as judged by present bio-assay methods for this complex dietary factor.

The stability of vitamin B_1 is dependent not only upon the heat treatment accorded it, but also upon the natural acidity of the food in which it is contained. In the more acid foods there is practically no loss of the vitamin during canning; in the less acid foods, which require longer and higher sterilization times and temperatures, the degree of retention is not as high.

Vitamin C is the most labile of all the vitamins; it is especially subject to destruction by open pan methods of cooking which permit free contact with atmospheric oxygen. In canning, however, the food is protected to a greater degree from contact with oxygen in the presence of heat; consequently the antiscorbutic factor is well retained in commercially canned foods.

Protective measures employed in commercial canning combine to insure that vitamins are retained in high degree. Such measures include the use of selected raw materials at the optimum state of maturity; prompt handling of the harvested crop; rapid inactivation of enzymes; removal of respiratory oxygen; and exclusion of air to a maximum extent during canning.

A fuller discussion of vitamin stabilities during canning procedures is not possible here. For further reading a recent publication dealing more in detail with this important subject is recommended (2).

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(1) The Vitamins, Sherman and Smith, The Chemical Catalog Co., New York, 1931.
The Vitamins; Browning, Bailliere, Tindall and Cox, London, 1931.
Vitamins, A Survey of Present Knowledge, Medical Research Council, H. M. Stationery Office, London, 1932.
(2) Ind. Eng. Chem. 24, 650 (1932)

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COUNTY SOCIETIES *and* ACADAMIES

First District

ACADEMY OF MEDICINE OF CINCINNATI

(H. J. Lavender, M.D., Secretary)

At the annual meeting of the Academy of Medicine of Cincinnati the following officers were elected for 1935-36: Dr. Charles J. McDevitt, president-elect; Dr. Donald J. Lyle, secretary; Dr. Charles E. Hauser, treasurer; Dr. V. Bradley Roberts, trustee (one year); Dr. Otto J. Seibert, trustee (two years); Dr. Louis Feid, Jr., trustee (three years). Delegates to the 1936 convention of the Ohio State Medical Association: Dr. Charles E. Kiely, one year; Dr. L. Howard Schriver, one year; Dr. Louis Feid, Jr., two years; Dr. Otto Seibert, two years; Dr. Henry B. Freiberg, three years; Dr. V. Bradley Roberts, three years; Alternate delegates: Dr. L. B. Johnston, one year; Dr. E. O. Swartz, one year; Dr. H. H. Shook, two years; Dr. T. A. Ratliff, two years; Dr. Wm. J. Topmoeller, three years; Dr. Chas. D. Heisel, three years. The new officers will be inducted into office Monday, September 30, when Dr. Edward D. King will assume the presidency.

Clermont County Medical Society met at the home of Dr. Frank H. Lever, Loveland, Wednesday evening, June 19. Dr. Clarence King, Cincinnati, discussed "Eye Conditions of Interest to the General Practitioner", and Dr. E. W. Mitchell, Cincinnati, spoke on "Fifty Years in General Practice".—J. M. Coleman, M.D., Secretary.

Clinton County Medical Society held its regular monthly luncheon meeting at the General Denver Hotel, Wilmington, Tuesday, June 4. Dr. Reyburn McClellan, Xenia, spoke on "What Becomes of the Water We Drink". Resolutions of regret and sympathy on the death of Dr. E. C. Briggs were read and adopted. A list of books in the Society's Medical Library, located in the Public Library, was announced as ready for consultation.—Elizabeth Shrieves, M.D., Secretary.

Fayette County Medical Society held its regular meeting Thursday noon, June 6, at the Cherry Hotel, Washington Court House, Ohio, with nearly a full membership present. The speaker was Dr. H. O. Bratton, Columbus, who gave a very interesting discussion on "Medical and Surgical Treatment of Hypertrophy of Prostate".—James F. Wilson, M.D., Secretary.

Warren County Medical Society was addressed by Dr. E. R. Arn, Dayton, on "Surgery of Malignancies of the Stomach and Colon", at the regular monthly meeting of the society held at

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OBSTETRICS—Informal Course—Two Weeks Intensive Course—Special Course, Gyn. & Ob., September 2nd.

FRACTURES AND TRAUMATIC SURGERY—Informal Course——Intensive Ten Day Course starting October 14th.

PEDIATRICS—Informal Course—Personal Courses.

EAR, NOSE AND THROAT—Informal Course—Intensive Two Weeks Course starting October 7th.

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Prompt and Full Report

Harmon Hall, Lebanon, Tuesday, June 4.—News Clipping.

Second District

Darke County Medical Society met at the Christion Church, Greenville, Friday evening, May 17. Dr. John A. Judy, Dayton, talked on "Hip Fractures".—W. D. Bishop, M.D., Secretary.

Greene County Medical Society was addressed by Dr. Benedict Olch, Dayton, on "The Heart After Forty", Thursday, June 6, at Xenia.—Reyburn McClellan, M.D., Secretary.

Miami County Medical Society was entertained by the Shelby County Medical Society at a joint meeting at the Sidney Country Club, Thursday, June 6. Dr. J. K. Hoerner, Dayton, talked on "Post-maturity, and Induction of Labor", and Dr. John Quirk, Piqua, discussed "Contusion of the Heart", with case report.—G. A. Woodhouse, M.D., Secretary.

Montgomery County Medical Society held its annual meeting at the Dayton Country Club, Friday afternoon and evening, June 7. A golf tournament and tennis matches featured the afternoon. Dr. Louis J. Karnosh, assistant clinical professor of nervous diseases, Western Reserve University School of Medicine, Cleveland, spoke on "Psychoses of Great Men", at the dinner. The following officers were elected and will assume their duties January 1, 1936; Dr. H. F. Hoppe, president; Dr. R. L. Johnston, vice-president; Dr. C. D. Smith, member of the censorship committee, and Dr. C. J. Derby, delegate to the Ohio State Medical Association.

Third District

Allen County—The Lima and Allen County Academy of Medicine and a number of guests attended a dinner, Thursday evening, May 23, at which Dr. O. E. Harvey, superintendent of the District Tuberculosis Hospital, was host. Speeches were given by Major Humphrey Ervin, Columbus, on "Reserve Officers Training Corps", and Dr. George W. Curtis, Ohio State University College of Medicine, who demonstrated methods of treating tuberculosis.—News Clipping.

Auglaize County Medical Society was addressed by Dr. O. E. Harvey, superintendent of the Lima District Tuberculosis Hospital, at a meeting at the Wapakoneta Courthouse, Thursday, May 30.—News Clipping.

Hancock County Medical Society held its regular monthly meeting at the Findlay Elks Club, Thursday, May 9. An interesting talk was given by Dr. William Gordon, Detroit, on the typhoid epidemic among the employes of the Ringling Brothers Circus, and the good results obtained from immuno transfusions. Dr. George Woldbott, Detroit, gave a very interesting illustrated talk on "Allergic Asthma".—R. S. Rilling, M.D., Secretary.

URINE
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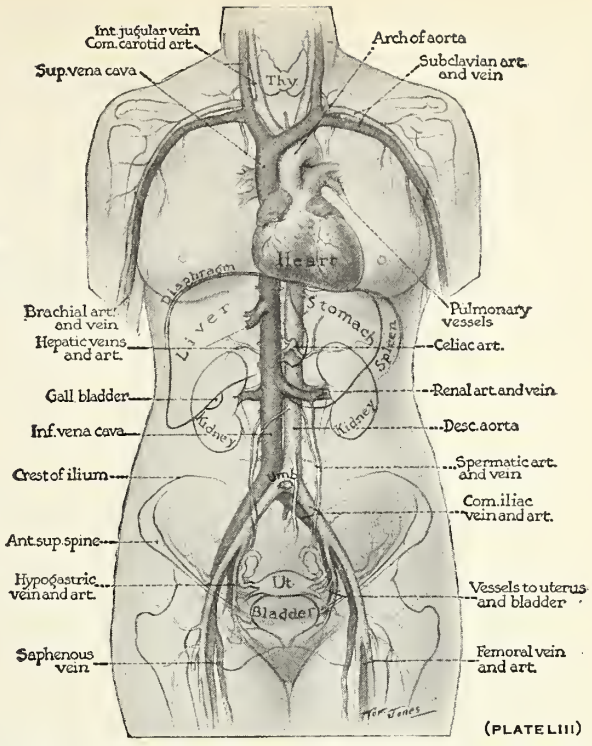
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Hardin County Medical Society met Thursday, May 16, at the Kenton Cafe. Dr. H. O. Bratton, Columbus, discussed "The Medical and Surgical Treatment of Prostratic Hypertrophy".—News Clipping.

Marion County—Marion Academy of Medicine, meeting Tuesday night, June 4, at the Hotel Harding, was addressed by Dr. George W. Crile, director of the Cleveland Clinic, on "Tumors of the Breast". Dr. George W. Crile, Jr., presented a case history.—News Clipping.

Fourth District

ACADEMY OF MEDICINE OF TOLEDO AND LUCAS COUNTY

(F. C. Clifford, Secretary)

A general meeting of the Academy was held at the Academy Building, Friday, June 7. Dr. A. J. Skeel, Cleveland, president of the Hospital Obstetric Society of Ohio and director of obstetrics at St. Luke's Hospital, Cleveland, discussed "Postpartum Hemorrhage", and Dr. Scott C. Runnels, Cleveland, secretary-treasurer of the Hospital Obstetric Society of Ohio and director of obstetrics, Huron Road Hospital, Cleveland, discussed "Maternal and Fetal Mortality".

The Surgical Section of the Academy was addressed Thursday, May 23, by Dr. P. J. Bidwell on "Some Observations on Skull and Brain Work". Discussants were Dr. L. A. Miller, Dr. P. G. Tait, and Dr. C. E. Hufford.

Henry County Medical Society met at Napoleon Tuesday, May 14. Dr. J. R. Bolles, county health commissioner, discussed "Diphtheria". Dr. Bolles urged that every child over six months old should be given one immunizing dose of alum precipitated diphtheria toxoid".—F. M. Harrison, M.D., Secretary.

Wood County Medical Society was addressed by Dr. F. B. Ficklin, Toledo, on "The Newer Treatment of Peptic Ulcer", at a meeting held Thursday, May 16, at the Women's Club, Bowling Green.—News Clipping.

Fifth District

ACADEMY OF MEDICINE OF CLEVELAND

(Justin A. Garvin, M.D., Secretary)

The Academy get-to-gether, for members, their wives and guests, was held at the Chamber of Commerce Club, Thursday, June 6.

Lorain County Medical Society met at the Hotel Lorain, Tuesday, May 14. Dr. Arthur Robishaw, Elyria, spoke on "The Caesarian Section".—News Clipping.

Trumbull County Medical Society held a joint meeting with the Warren Dental Society at the Trumbull County Country Club, Warren, Wednesday, May 22. The speaker was F. Marshall Weaver, D.D.S.—News Clipping.

Sixth District

Ashland County Medical Society held a dinner-

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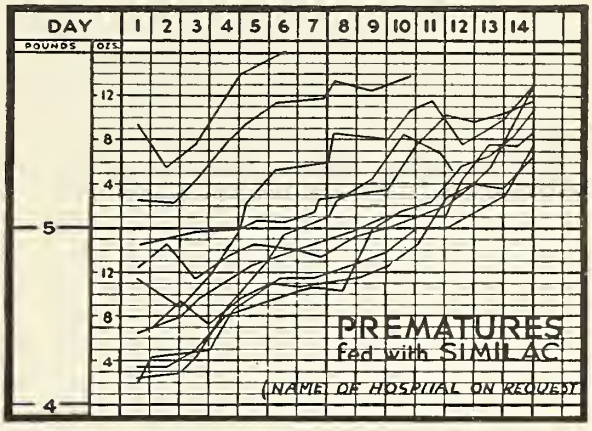
The observations referred to covered only three prematures fed on different fats, but showed an average of 78.4% retention for olive oil as compared to only 52.5% retention for butter fat.

*Holt, Tidwell and Kirk, Studies on Fat Metabolism in Infants—Acta Pediatrica. Vol. XVI, 1933.

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meeting, Friday, May 10. The subject of the address made by Dr. Carl D. Postle, Columbus, was "History of Cataract of the Eye".—News Clipping.

Mahoning County Medical Society was addressed by Dr. William H. Gordon, Detroit, on "Malignant Neutropenia", at a meeting held at the Youngstown Club, May 21.—Bulletin.

The June meeting of the society was held Tuesday, June 18. The speakers were Dr. Arthur G. Hyde, superintendent of the Massillon Hospital, who discussed "Modern Treatment of Mental Diseases", and Dr. Arthur O. Gillam, assistant superintendent of the hospital who talked on "Hallucinations and Diagnosis".—Bulletin.

Portage County Medical Society met at the residence of Dr. R. D. Worden, Ravenna, Thursday, June 6. Dr. A. F. Sydow spoke on "The Treatment of Burns".—E. J. Widdecombe, M.D., Secretary.

Summit County Medical Society met at the Mayflower Hotel, Akron, Tuesday, June 4. Addresses were given by Dr. W. M. Brand, Toledo, on "The Breech", and Dr. J. L. Reycraft, associate clinical professor of gynecology, Western Reserve University School of Medicine, on "A Study of Tubal Patency".—Bulletin.

Wayne County Medical Society held a dinner-meeting at Orrville, Friday, May 24. Dr. Louis J. Karnosh, City Hospital, Cleveland, gave an interesting talk on mental cases.—R. Clifford Paul, M.D., Secretary.

Seventh District

Belmont County Medical Society met at Bellaire, Friday, May 10. Dr. J. C. F. Wilkinson read a paper on "Empyema". The physician's part in medical relief work was discussed.—News Clipping.

Coshocton County Medical Society met at the Nurses' Home, Coshocton City Hospital, Thursday evening, May 23. Dr. S. B. Kistler was the principal speaker.—News Clipping.

Jefferson County Medical Society held its annual dinner meeting at the Steubenville Country Club, Thursday, May 23. Members of the Seventh District were invited and enjoyed golf in the afternoon. Dr. Thos. E. Jones, Cleveland, spoke on "Acute Intestinal Obstruction".—John Y. Bevan, M.D., Secretary.

Tuscarawas County Medical Society held a meeting Thursday, May 9, at Dover. Dr. Donald M. Glover, Cleveland, gave an illustrated lecture on "Injuries and Infections of the Hands and Feet". County Relief Director Graham spoke on the problems of medical relief.—Bulletin.

Eighth District

Athens County Medical Society was addressed by Dr. Charles McGavran, Columbus, on "1935 Diabetic Problems", at its meeting at the Ameri-

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can Legion Home, Athens, June 4.—News Clipping.

Licking County Medical Society met at the Newark Hospital, Friday, May 31. Dr. Wm. Gillespie, College of Medicine, University of Cincinnati, spoke on "Complications of Labor".—G. A. Gressle, M.D., Secretary.

Muskingum County Academy of Medicine held a dinner meeting at the Hotel Rogge, Zanesville, Wednesday evening, June 5. "Use of Drugs in Treatment of Heart Disease", was the subject of a paper read by Dr. A. Z. Ernstine, Cleveland. Dr. W. J. Gardner, Cleveland, discussed "Surgical Lesions of the Cerebral Blood Vessels".—Beatrice T. Hagen, M.D., Secretary.

Ninth District

Scioto County—The regular monthly meeting of the Hempstead Academy of Medicine was held at the recreational hall, Nurses' Home, Portsmouth, Monday evening, June 10. Dr. Geo. B. Brown spoke on "Differential Diagnosis of Acute Eyes". "The Acute Ear", was discussed by Dr. H. A. Green. Dr. H. H. Morris gave a talk on "Bronchoscopy".—Wm. E. Scaggs, M.D., Secretary.

Tenth District

COLUMBUS ACADEMY OF MEDICINE

(Drew L. Davies, M.D., Secretary)

June 3—"Infections and Injuries of the Hand", by Dr. Sumner L. Koch, assistant professor of surgery at Northwestern University Medical School, and attending surgeon in Passavant Memorial and Cook County Hospitals, Chicago, Illinois.

June 10—The Academy met at Columbus State Hospital, where the following program was presented: Dr. Isabel A. Bradley, "Bromide Intoxication"; Dr. Beatrice Postle, "Relation of Endocrinology to Mental Diseases"; and Dr. H. A. Fockler, "Encephalitis".—Bulletin.

Crawford County Medical Society met at the Bucyrus City Hospital, Monday, June 3. Dr. H. W. Todd, Galion, gave the members a description of his tour in the South Sea Islands during his recent trip around the world. Robert L. Jentgen, county relief director, outlined his plans for the medical relief set-up in the county.—News Clipping.

Morrow County Medical Society held a meeting at the Globe Hotel, Mt. Gilead, Tuesday evening, June 4, at which Dr. John E. Rauschkolb, Clinical Professor of Dermatology and Syphilology, Western Reserve University, School of Medicine, was the speaker. His subject was "Common Skin Diseases As Seen by the General Practitioner", and his talk was made more interesting by slides demonstrating the various conditions described.—Todd Caris, M.D., Secretary.



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AS A MEDIUM OF SERVICE TO ITS MEMBERS

AUGUST 1, 1935 VOL. XXXI Number 8

89th ANNUAL MEETING

Cincinnati, O. October 2, 3, 4, 1935

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SEE THIS ISSUE FOR LIST OF CINCINNATI HOTELS AND OTHER ANNUAL MEETING INFORMATION

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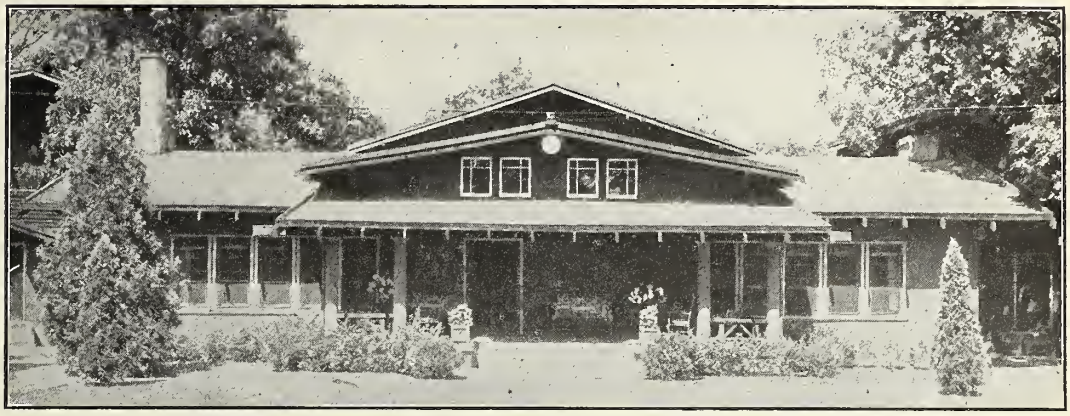
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The Ohio State Medical Journal

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Medina	F. C. Reuter, Spencer	J. K. Durling, Wadsworth	3d Thursday, monthly.
Trumbull	M. T. Knappenberger, Warren	A. H. Seiple, Warren	2d Tues., monthly, Sept.-May.

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Sixth District	R. S. Friedley, Akron	K. H. Harrinton, Akron	2d Wed., Jan., April and Oct.
Ashland	L. G. Sheets, Ashland	M. J. Thomas, Jeromesville	2d Friday, Sept. to May
Holmes	Clyde Bahler, Walnut Creek	C. T. Bahler, Walnut Creek	1st Wed., Feb., Apr., June, Aug., Oct., Dec.
Mahoning	J. L. Fisher, Youngstown	W. M. Skipp, Youngstown	3d Tuesday, monthly.
Portage	A. M. Landsborough, Garrettsville	E. J. Widdecombe, Kent	1st Thursday, monthly.
Richland	B. E. Shreffler, Mansfield	H. C. Winbigler, Mansfield	Last Thursday, monthly.
Stark	M. E. Scott, Massillon	H. W. Beck, Canton	2d Tues., monthly, except July and Aug.
Summit	J. D. Smith, Akron	A. S. McCormick, Akron	1st Tuesday, montbly.
Wayne	W. A. Fritz, Wooster	R. C. Paul, Wooster	4th Friday, monthly.
Seventh District			
Belmont	W. L. Davis, Martins Ferry	C. W. Kirkland, Bellaire	1st Thurs., monthly, 4 p. m., except July and August.
Carroll	(With Stark Co. Society)		
Columbiana	F. R. Crowgey, Salem	G. E. Byers, Salem	2d Tuesday, monthly.
Coshocton	C. M. Neldon, Cosbocton	J. D. Lower, Coshocton	4th Thurs., monthly.
Harrison	A. C. Grove, Jewett	W. C. Wallace, Hopedale	3d Wednesday, monthly.
Jefferson	W. H. Minor, Steubenville	J. Y. Bevan, Steubenville	3d Tuesday, monthly.
Monroe	G. W. Steward, Woodsfield (dec'd)	A. R. Burkhart, Woodsfield	2d Wednesday, monthly.
Tuscarawas	R. J. Foster, New Philadelphia	C. M. Dougherty, New Phila.	2d Thursday, monthly.
Eighth District			
Athens	W. E. Howe, Nelsonville	T. A. Copeland, Athens	1st Monday, monthly.
Fairfield	K. W. Taylor, Pickerington	C. W. Brown, Lancaster	2d Tuesday, monthly.
Guernsey	C. A. Craig, Cambridge	Reo Swan, Cambridge	1st and 3d Thursday each month.
Licking	Geraldine Crocker, Granville	G. A. Gressle, Newark	Last Friday, monthly.
Morgan	D. G. Ralston, McConnelsville	C. E. Northrup, McConnelsville	3d Tuesday, monthly.
Muskingum	W. D. Coffman, Zanesville	Beatrice C. Hagen, Zanesville	1st Wednesday, monthly.
Noble			
Perry	C. B. McDougal, New Lexington	F. J. Crosbie, New Lexington	3d Monday, monthly.
Washington	A. H. Smith, Marietta	R. M. Meredith, Marietta	2d Wednesday, monthly.
Ninth District			
Gallia	E. G. Lupton, Gallipolis	Milo Wilson, Gallipolis	1st Wed., Feb., May, Sept. and Dec.
Hocking	J. L. Webb, Nelsonville	M. H. Cherrington, Logan	2d Thursday, monthly.
Jackson	J. S. Hunter, Jackson	J. J. McClung, Jackson	2d Tuesday, monthly.
Lawrence	R. F. Massie, Ironton	W. W. Lynd, Ironton	1st Thursday, monthly.
Meigs	H. M. Crumley, Pomeroy	R. E. Boice, Middleport	3d Thursday, bi-monthly.
Pike	L. E. Wills, Waverly	R. T. Leever, Waverly	1st Monday, monthly.
Scioto	R. P. Elder, Portsmoutb	Wm. E. Scaggs, Portsmouth	2d Monday, monthly.
Vinton	O. S. Cox, McArthur	H. D. Chamberlain, McArthur	3d Wednesday, monthly.
Tenth District			
Crawford	M. L. Helfrich, Galion	C. J. Griebling, Galion	1st Monday, monthly.
Delaware	J. K. James, Delaware	W. E. Borden, Delaware	1st Tuesday, monthly.
Franklin	E. G. Horton, Columbus	Drew Davies, Columbus	1st four Mondays, monthly.
Knox	E. V. Ackerman, Fredericktown	R. L. Eastman, Mt. Vernon	Last Thursday, monthly.
Madison	R. W. E. Irwin, Mt. Sterling	F. A. Lutz, Mt. Sterling	4th Wednesday, monthly.
Morrow	E. C. Sherman, Cardington	T. Caris, Mt. Gilead	Last Thursday, monthly.
Pickaway	R. S. Hosler, Ashville	E. R. Austin, Circleville	1st Friday, monthly.
Ross	O. P. Tatman, Chillicothe	W. C. Breth, Chillicothe	1st Thursday, monthly.
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RECENT ADVANCES IN THE TREATMENT OF PERIPHERAL VASCULAR DISEASES *

By MONT R. REID, M.D., CINCINNATI, OHIO

INTRODUCTION

IT IS only about a century and a half since members of our profession began to suspect that certain ills of man might be due to deterioration in the functioning of blood vessels. Throughout the sixteenth and seventeenth centuries "ossified" and "bone-like" arteries excited the interest of many great physicians but it was not until the last quarter of the eighteenth century that Morgagni and Fothergill suspected the causal relationship between degenerative changes of the coronary arteries and the clinical condition of angina pectoris. In the early nineteenth century Baillie and Hodgson explained apoplexy on the basis of diseases and rupture of the cerebral blood vessels. And then came the epoch-making linking together of cause and effect when in 1837 Carswell and Cruveilhier (1829-42) attributed peripheral gangrene to an obliteration of the peripheral arteries and thus dispelled the old idea that it was due to a lack of innate heat.

In 1829-33 Lobstein gave us the term "arteriosclerosis" and very soon it was used to denote all forms of arterial disease.

But for a great many years blood vessel diseases remained a subject of primary interest mainly to the pathologists. Throughout the pages of the textbooks of pathology the gradual disorders in function of the various parts of the human body have been and still are measured in terms of the recognizable changes in the blood vessels.

Then recently and rather suddenly came the full realization on the part of the medical profession in general that diseases of the arteries directly and indirectly were responsible for more deaths than all other diseases combined. Today, consciously or unconsciously, a consideration of blood and blood vessels is playing a very important role in the practice of all branches of medicine. An attempt to order the lives of our patients, warnings against the stress and strain of modern life and the prescribing of vacations and rests in Florida, find their rationale in prolonging the normal function of blood vessels. The surgeon's judgment as to action and actual operative procedures is not infrequently greatly influenced by a general idea of the condition of the patient's vascular system.

Perhaps, as a result of their general realization of the important role of the blood vessels both in the duration of life and in the daily physiological function of our bodies and, perhaps partly, as a result of the amazing progress in the control and elimination of many infectious diseases, the minds of countless clinicians have recently been centered on this fundamental problem of conserving the function of blood vessels. An enormous accumulation of literature within the past few years records the interest of internists, cardiologists, psychiatrists, cancer research workers, physiologists and surgeons in the field of this fundamental problem.

A matter of particular interest to surgeons has been the study and treatment of the peripheral vascular diseases.

Read before the Fourth General Session, Ohio State Medical Association, at the 88th Annual Meeting, Columbus, October 4-6, 1934.

From the Department of Surgery of the College of Medicine of the University of Cincinnati, and of the Cincinnati General Hospital.

DIAGNOSTIC PROCEDURES

For the study of these conditions many new procedures have rather recently been brought into use. In 1842 Jean Cruveilhier bemoaned the fact that there were no sure signs which would permit the recognition of obliterated arteries during life. It was not long, however, until the blood pressure apparatus and means of recording pulse tracings gave considerable impetus to the study of the condition of the peripheral arteries. Considerably later came the epoch-making tests of Matas, Moskowicz and others for estimating the value of the collateral circulation and of determining the optimum level for amputation. It is undoubtedly true that the next great impetus to efforts to evaluate the condition of the peripheral arteries was born of the work of Royle and Hunter who reported in 1924 concerning the vasospastic effects of the sympathetic nervous system. Whatever the ultimate value of their work it caused many investigators to attack the problem of studying peripheral vascular disease with renewed interest. Brown (1926) with the use of intravenous injection of typhoid vaccine, gave us a method of arriving at gradients to express the rôles of vasospasm and organic obstruction in peripheral vascular disease. Morton and Scott (1930) showed that the vasospasm could be completely overcome by the use of spinal anaesthesia; White produced a similar effect by blocking the regional sympathetic ganglia with novocaine. The same year (1930) Lewis and Pickering and later Coller (1932) reported that, for practical purposes, vasomotor relaxation could be obtained by wrapping a patient in hot woolen blankets until the body temperature rose one or two degrees.

Gibbon and Landis have revived and standardized the use of contrast baths of hot and cold water both for the study and treatment of peripheral vascular diseases. They have stressed their effects both directly upon extremities and remotely through reflex action. To these various procedures I have enumerated may also be added many others of definite value—the effect of position on the color changes of the skin; roentgenologic studies of the arteries with and without visualization; a study of the calcium content and of the viscosity of the blood; the condition of the heart; blood sugar determinations; routine Wassermann reaction; basal metabolism; pulse rate, etc. All of these procedures have a definite value in getting a general picture of the problem with which one may be confronted in dealing with a case of peripheral vascular disease.

MECHANICAL DEVICES TO HELP IN MAKING A DIAGNOSIS

In addition to these procedures various mechanical devices have been developed or brought to aid in the study of peripheral vascular diseases. Time will not permit me to trace their development; it will suffice to make only mention of them — the modern oscillometer (Boulitte-Pachon); the dermatherm (Tycos-Scott); the plethysmograph and apparatus for micro-capillary studies; and for accurate scientific studies a constant temperature room is almost necessary.

While there is today considerable variation in the procedures and methods used by different investigators to study peripheral vascular diseases, I think it safe to say that the oscillometer, the Tycos dermatherm and some procedure for estimating the element of vasospasm are the most important aids to the clinical history and physical examination in arriving at an accurate diagnosis and appraisal of vascular deficiency in cases of peripheral arterial disease. Estimating the element of vasospasm involves some procedure for producing vasomotor relaxation. In our clinic and some others the body temperature is raised one or two degrees by means of hot blankets. In various clinics one will find the use of typhoid vaccine, spinal anaesthesia and regional sympathetic nerve block. Any of these procedures which temporarily produce vasomotor relaxation will permit the oscillometer and dermatherm to measure fairly accurately the element of vasospasm.

A generation ago the instruments and procedures for the study of peripheral vascular disease were primarily for determining the best level for amputation. Today they are primarily used to give us an idea of what may possibly be done to restore an extremity to usefulness and to prevent an amputation. It is an entirely different but rational and hopeful viewpoint.

CLASSIFICATION OF PERIPHERAL VASCULAR DISEASES

With the accumulated knowledge of blood vessels contributed through the years by pathologists, physiologists and investigating clinicians it has been only natural that the all-inclusive term "arteriosclerosis" introduced by Lobstein in 1832 could not suffice to describe the variations in the clinical and pathological manifestations of all kinds of peripheral vascular disease. In the course of time various groups of vascular manifestations have been segregated from the parent trunk and given names of their own.

Thus in 1862 Raynaud, under the title of "The Local Asphyxia and the Symmetrical Gangrene of the Extremities," gave us an excellent clinical picture of a group of vascular conditions which has since been known as Raynaud's disease. This condition characterized by alternating attacks of ischaemia, redness, cyanosis and severe pain, often associated with tissue induration and symmetrical gangrene is familiar to all of you and is the classic example of a vascular condition which is due essentially to a vasospastic disturbance. Attempts have been made to segregate other groups of vasospastic disturbances and to classify them un-

der such terms as "acrocyanosis," "acroparesthesia," "chronic acroasphyxia," "sclerodactylia," "multiple neurotic gangrene," "scleroderma," etc. However, the lines of demarcation between these various conditions are not clear cut, making it difficult both clinically and pathologically to classify these closely related conditions. In many of these conditions the vasomotor nerves may be at fault reflexly rather than primarily. The vague term of "acrocyanosis" is used most frequently to designate these closely allied conditions.

The classic example of a vasodilatory disturbance was described by Weir Mitchell in 1878 under the title of "erythromelagia." It is often known as Weir Mitchell's disease and is characterized by continuously red and often painful extremities. Acute painful osteoporosis is sometimes attributed to vasodilatory disturbances.

Thus an effort is being made to separate from arteriosclerosis a whole group of primary vasomotor disturbances and to classify them. This work is yet very incomplete and little understood mainly because the etiologic factors are not known.

While to Raynaud belongs the credit for starting a study and classification of the vasomotor peripheral vascular diseases, it may be said that von Winiwarter pointed the way toward a further classification of the organic diseases which were still grouped under the general heading of "arteriosclerosis." In 1879 he reported a "Peculiar Form of Endarteritis and Endophlebitis with Gangrene of the Foot." He described most accurately the clinical syndrome of migratory phlebitis, intense pain, blanching of the elevated foot and cyanosis of the dependent foot; also the pathologic involvement of the veins and nerves as well as the arteries. He noted the occurrence of the condition in relatively young people, its tendency to affect both legs and its predilection for members of the Jewish race. He called it "arteritis obliterans." This condition continued to be known in this country as "presenile gangrene" until Buerger's classic study and report in 1908, since which time the American terminology has usually been either "Thromboangiitis obliterans" or "Burger's Disease."

In the same age group one not infrequently meets with a condition which is essentially a thrombosis of the arteries and does not involve the veins or nerves. It is usually unilateral and is a vastly different problem both from the standpoint of prognosis and treatment than is Buerger's disease with which it is at the present time usually confused. What appears to be the most appropriate and descriptive term for it is "Endarteritis obliterans."

Other types of apparently inflammatory peripheral arterial disease less frequently encountered, are the cases of specific arteritis due to syphilis, tuberculosis and pyogenic periarteritis nodosa. Herrmann has recently reported three new cases of luetic peripheral vascular disease, two of which were associated with extensive arterial obliteration. In all, there have been about 25 cases reported. Tuberculosis is much rarer and periarteritis nodosa is a pathological curiosity usually involving the mesenteric arteries and almost never diagnosed during life.

In some countries, particularly Russia and possibly this country, cases of non-specific arteritis due to ergotism are frequently observed. Less frequently there are cases apparently associated with the exanthemata, typhus or typhoid fever.

The traumatic organic peripheral vascular diseases represented principally by embolism and thrombosis, arteriovenous and simple aneurysms, phenol gangrene and frost bite, are usually recognized and properly classified.

Due to the urgent necessity of treating the diabetes in patients who have arteriosclerotic peripheral vascular disease, it has wisely become the custom to speak of diabetic gangrene or diabetic arteriosclerosis rather than arteriosclerotic gangrene in a patient who has diabetes.

The conditions still classified as arteriosclerosis are the cause of the vast majority of chronic obliterative arterial diseases. In general, the changes regarded as degenerative and usually associated with advancing age are lumped together and called "arteriosclerosis." Among these changes it is admitted that there are great variations, and some investigators make subdivisions such as the nodular, senile, arteriolar and Mönckeberg's types. In the present state of our knowledge, these types appear to represent variations or stages of the same fundamental pathologic process. Yet in the study and treatment of peripheral vascular diseases it seems to be of definite prognostic and therapeutic value to try to recognize varieties of arteriosclerosis, especially the Möncheberg's and senile types. Undoubtedly, as time goes go and after specific etiologic factors have been discovered, these variations of arteriosclerosis will become more readily recognizable and be split from the parent trunk under names of their own.

Classification of Peripheral Vascular Diseases, used in the Vascular Disease Clinic of the Cincinnati General Hospital:

A. Primary Vasomotor Disturbances
  a) Vasoconstrictor Disturbances
    1) Raynaud's Disease
    2) Acrocyanosis (Acroasphyxia chronica; Acroparesthesia; Sclerodactylia)
  b) Vasodilatory Disturbances
    1) Erythromelalgia
    2) Acute painful osteoporosis (?)
B. Primary Organic Diseases of the Arteries*
  a) Traumatic (chemical and thermal)
    1) Embolism and simple thrombosis

*Vasospasm may occasionally play a constant part in the picture of the obliterative disease; it frequently plays a temporary but very important part during the sudden critical periods of all vascular diseases.

2) Arteriovenous aneurysm
3) Phenol and all caustics
4) Frost bite

b) Inflammatory (toxic)
1) Thromboangiitis obliterans
2) Specific arteritis (syphilis, tuberculosis, periarteritis nodosa pyogenic)
3) Non-specific arteritis (exanthemata, typhus, typhoid, pneumonia)
4) Non-specific arteritis (chronic toxemia, ergotism)
5) Endarteritis obliterans (cause undetermined)

c) Degenerative changes
1) Arteriosclerosis (senile, diabetic and Mönckeberg)

While the accumulated knowledge justifies the attempt to fit any given case of peripheral vascular disease into one's working classification, the problem is by no means a simple one. Any long standing case will usually exhibit some of the characteristics of two or more of the various types of peripheral vascular disease. What was in the beginning a true case of Raynaud's disease may show later organic obliteration of many peripheral vessels due to thrombosis and fibrosis. An arteriosclerotic case may develop a sudden occlusion of various vessels due to thrombosis or a cardiac embolism. When any case of primary organic disease develops a sudden critical period such as may be brought on by thrombosis, embolism, rupture of a vessel, injury, exposure to cold, etc., there is always superimposed an element of vasospasm which may be temporarily but still a very vital factor during a critical period when gangrene is so likely to develop.

In general, it may be said that as long as a given chronic peripheral vascular condition remains pure and runs its usual gradual course the critical periods of threatening gangrene are very few and not infrequently the patient is unaware of the existence of any peripheral vascular disease. Notable exceptions to this generalization are thromboangiitis obliterans and the arteriolar type of arteriosclerosis. Even Raynaud's extremities when not subjected to the vasospastic irritation of fluctuating heat and cold may run for years with very little disability.

These few brief remarks concerning the study of peripheral vascular diseases, their classification and the frequency of combined pathological processes justify at this point, I think, a repetition of some generalizations I have previously published.

"This critical way of studying peripheral vascular diseases has tremendously broadened the vision of our problem. Not only are we classifying our cases better, more accurately estimating the degree of vascular deficiency, and determining the rôle of vasospasm but there have been other interesting results. Earlier diagnoses are being made; students, nurses, internes and staff members are developing the habit of feeling the pedal pulses; the blood supply of the arteries is being considered when planning and executing operative procedures. But most significant of all is the gradual realization that there are thousands of people working and living their lives unmindful of their narrow margin of safety due to absent palpable pulsations in the arteries of their feet, that there are many others being treated for fallen arches, metatarsalgia, cramps, rheumatism, etc., when the pain is due to a blood supply insufficient to meet the demands of the tissues for oxygen, and that the vast majority of our patients come from these unsuspecting individuals who, for reasons of cold, slight injury or infection have developed a necrotizing process with which the decreased blood supply cannot cope and that help is demanded to restore a livable balance between the demands of the tissue for blood and the blood supply or else gangrene will develop.

"We have amply confirmed the observations of others, that oscillometric and thermometric studies may indicate a better circulation in a foot showing a beginning gangrene than in the opposite foot which has caused no discomfort. In such cases neither foot has the vitality to withstand an insult to its tissues, which happens to come to the foot exhibiting evidences of the better circulation. Frequent observations confirm the belief of many that the most critical period in the course of peripheral vascular diseases is when the main arteries become finally occluded. If the occlusion be a very gradual one the patient may not experience any discomfort; if it be rather sudden, actual or threatening gangrene may follow. In such cases an element of spasm is added to the rather abrupt demand which is thrown upon the collateral circulation. Cannot many of these patients be tided through the critical phases of their disease until a livable balance is established between the blood supply and the demands of the tissues for it? Are we not on the threshold of enormous progress in preventive and curative measures which will make amputations for peripheral vascular disease a relatively infrequent occurrence?"

TREATMENT OF PERIPHERAL VASCULAR DISEASES

With our present increased knowledge of these conditions there naturally comes the practical question: What can be done to prevent the suffering and the amputations incident to the peripheral vascular diseases? First and foremost comes that old familiar cry of "early diagnosis and early treatment" which is written through the pages of medical literature and has rung through the halls of society meetings in connection with appendicitis, cancer and most other problems which have confronted the medical profession. Connected with this problem there is a vast and, as yet, an almost untouched field of

preventive medicine. Nine times out of ten, the routine examination of the heart, kidneys and other organs is but an effort to estimate the efficiency of the blood vessels of these vital organs and to learn if it may be necessary to take measures to forestall trouble that is lurking in the future. The time is already upon us when an estimate of the blood supply to the extremities should be an integral part of the routine physical examination of all patients. With the oscillometer and simple observations as to the effect of position upon the color of the feet, we can get a still more accurate idea of the vascular efficiency of the extremities. The means for estimating peripheral vascular efficiency are almost as accurate as are the means of estimating the efficiency of the blood vessels of the heart and kidney. They are waiting to be put into general use by our profession. Once it becomes the practice to study the peripheral vessels and to advise people when there is a thin margin of safety in the blood supply of their legs, there are many things that can be done to avoid those critical periods of pain, infection, gangrene and amputation. Then, too, there will be a noticeable diminution in the number of patients treated for cramps, metatarsalgia, fallen arches and rheumatism.

When peripheral vascular conditions are recognized early and before the onset of severe pain and the signs of impending gangrene much can be done to forestall trouble. It may be well to note here some of these general measures and advice: The avoidance of injury and infection; the absolute necessity of keeping the feet warm; the immediate and most meticulous care of the slightest wound or infection; keeping the skin of the feet in the most perfect condition by means of baths, oils and greases; the avoidance of positions or exercises that may tend to traumatize the main arterial pathways; a very large fluid intake; a judicial use of thyroid extract when the pulse is slow and the blood pressure low; the eradication of all foci of infection; abstinence from the use of tobacco; the Buerger or Allen vascular exercises, etc.

Elsewhere I have recounted the story of a man with Raynaud's disease who went for years in comfort by taking the most painstaking care of the skin of his hands, and by never permitting them to be subjected to sudden changes of temperature. We are all familiar with the infrequency of trouble in the remaining leg when, by reason of amputation of the other leg, a patient has been forced to be careful. In many such instances good general care instituted beforehand would have prevented the loss of either leg.

However, as the situation now stands we are being usually confronted by patients who, as the result of a sudden occlusion (usually by thrombosis) of an already diseased artery, of injury or cold or neglect, present the acute problems of severe pain, ischaemia, mottling, threatened or actual gangrene. For these acute crises of peripheral vascular disease which, unfortunately, at the present time, constitute our major vascular problems, combinations of many therapeutic procedures are in use, such as rest; proper level of the affected extremity; superheated air; hypodermoclysis with large quantities of Ringer's solution daily; intraduodenal administration of large amounts of hypertonic salt solution; intravenous administration of sodium citrate solution; constrictive hyperemia; intravenous administration of sodium iodide and calcium chloride; the use of vasodilating drugs; the ligation of the femoral vein; periarterial sympathectomy and sympathetic ganglionectomy; ligation or excision of the femoral artery; paralysis of the peripheral sensory nerves.

The various procedures which we stress in our hospital care of these acute problems are listed in this paper.

ROUTINE IN HOSPITAL FOR PATIENTS WITH PERIPHERAL VASCULAR DISTURBANCES

Name..... Disp. No.....
Hosp. No..... Ward..... Date.....

1. Bed should be fitted with a Balkan frame with hand grips to aid patients in carrying out exercises and permit patients to move around in bed easily.
2. Affected extremity or extremities should be placed on a pillow in the position which affords optimum circulation to the part. Heels should extend over the edge of the pillow to prevent excessive pressure from the mattress.

   Position of optimum circulation as determined in the Vascular Clinic:

   A. Right foot
      a) Recumbent position .....
      b) Sitting position .....
   B. Left foot
      a) Recumbent position .....
      b) Sitting position .....
3. Large, doubly insulated cradle over the legs and feet, when necessary to relieve pressure of bed covers. Cradle should NOT be fitted with electric bulbs or other mechanical heating devices, but the legs kept warm with large woolen or flannel stockings, or by keeping the room warm.
4. Well-balanced, liberal diet.
5. Drink at least four quarts of water each day.
6. Patients should abstain from the use of tobacco in any form.
7. Daily cleansing of the feet. Careful application of neutral (face) soap and warm water followed by alcohol (70 per cent). Dry feet without friction. Apply vaseline or bland oils to roughened or irritated areas. Special care should be given to the toenails and thick callouses.
8. Ulcerated areas on the extremities should be treated as follows:

   .....
   .....

9. Use only non-habit forming drugs for the relief of pain in the extremities.
10. Postural treatments as advised by Buerger and modified by Allen should be carried out as follows:
11. Pavaex treatments as follows:.....
12. All diabetic patients are simultaneously under the care of the Medical and the Surgical Services.
13. All important clinical studies on the patients with peripheral vascular disturbances should be made in the Vascular Clinic of the Dispensary.

....., M. D.

In those critical periods of peripheral vascular disease in which there is a rapid or sudden threat of gangrene the use of passive vascular exercises (Pavaex treatment) has certainly been responsible for the saving of many limbs which would otherwise have had to be amputated. It has certainly been the most effective single stimulant to the development of livable collateral circulation.

The idea of the use of negative environmental pressure in the treatment of various vascular conditions is, of course, not new. In recent articles in which our present apparatus is accurately described we have reviewed the works of Bier, Willy Meyer and Schmieden, Klapp, and others, bearing upon the suction treatment of the various conditions of the extremities. Sinkowitz and Gottlieb in 1917 reported excellent results by Bier's suction hyperemia in four cases of thromboangiitis obliterans. Braeucker in 1931 treated 19 cases of true Raynaud's disease by the Bier method of hyperemia. He advocated the continued use of partial vacuum for periods of from thirty minutes to two hours, and this was repeated twice each day.

It is unnecessary and would be uninteresting to repeat here a description of our present machine which is on the market under the name of the "Pavaex Treatment Unit." The word "Pavaex" was selected by Herrmann as a contraction for "passive vascular exercises" and is used to designate this form of therapy in contrast to the active vascular exercises of Buerger or Allen. It will suffice to say that the machine runs automatically, can be set to run any length of time desired, and is capable of producing any strength of alternating negative and positive environmental pressures as frequently as thirty times to the minute. Slight variations in the amount of negative and positive pressures are necessary for different cases. Ordinarily the selector switches are set for 80 mm. of mercury negative pressure and 20 mm. of mercury positive pressure. The average rate of alternation that we have found most beneficial is approximately one complete cycle in thirty seconds. However, with improvement in the circulation the time of the cycles may be advantageously changed to fifteen seconds. The average duration of one treatment is two or three hours, but in severe cases of threatened gangrene, it may be necessary to give the treatment almost constantly.

When a patient with peripheral vascular disease develops a sudden or rapid occlusion of a main artery there is necessity for quick relief or else gangrene may occur within a few hours. A similar problem is presented in cases of frost bite or cardiac emboli lodging in normal arteries. During the past two years we have had occasion to observe and treat many such cases of impending gangrene. The rapid results in the relief of pain and the prevention of gangrene by the use of alternating negative and positive environmental pressures have been the most spectacular things I have seen in my practice of surgery. Our experience with Pavaex treatments has convinced us that it is no longer necessary to operate for peripheral emboli or to have gangrene develop after the ligation of large arteries for aneurysm, trauma, etc.

The symptoms of intermittent claudication, arch pain and even gangrene arising from a more gradual involvement of the primary and secondary arteries have generally been completely relieved by the addition to our routine of the use of Pavaex treatments. Into this group fall most of the cases of diabetic arteriosclerosis.

There are certain types of peripheral vascular disease in which the use of passive vascular exercises may be of a secondary rather than a primary therapeutic value. This may be true in cases of acute thromboangiitis obliterans and arteriolar arteriosclerosis in which the general care I have outlined seems to be of the greater importance. Although an element of vasospasm is usually present in these two conditions our conviction is that sympathetic nervous system surgery is contraindicated. Except in Raynaud's disease and other primary vasospastic conditions, operations on the sympathetic nervous system for peripheral vascular disease have practically been abandoned in the Surgical Clinic of the Cincinnati General Hospital. Passive vascular exercises with a graded scale as to its importance in the therapy as outlined above is being used in all cases.

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HYPOCHROMIC ANEMIA

By RUSSELL L. HADEN, M.D., Cleveland, Ohio

ERYTHROCYTES are present in the circulation in sufficient quantity to constitute normally almost one-half the total volume of blood. Each cell lives only a few weeks, disintegrates, and is replaced by a new one formed in the marrow of the flat bones. The spleen acts as a storehouse of mature red cells ready to enter the circulation in response to any acute need. The circulating erythrocytes, the reserve supply, and the developing red cells in the marrow, together constitute an organ just as definitely as the cells of the liver collectively make a single organ. For this organ, Boycott[1] has proposed the name, erythron.

The volume of the marrow is normally about 1400 c.c. and a man of average weight has about 2000 c.c. of erythrocytes in the circulation, so the erythron is by far the largest organ of the body. The red cells should be thought of primarily as constituting this organ which is essential to life since it alone can transport oxygen from the lungs to the tissues in adequate amounts. We can calculate the total mass of circulating cells from the blood volume and hematocrit reading and thus measure relatively the size of the erythron since the circulating cells usually vary directly with changes in the marrow. In Figure 1 are shown actual measurements of the circulating portion of the erythron in various blood dyscrasias.

With the conception of the erythron as an organ, its component parts, the erythrocytes, are next to be considered. These vary greatly in number, volume and color in the blood dyscrasias, although they normally are remarkably constant. From the red cell count and the hematocrit reading the volume of the mean cell can easily be calculated and this reflects accurately also the state of the cells in the marrow. The volume relative to normal is shown by the volume index. The actual transport of oxygen from lungs to tissues is by means of hemoglobin, which, traveling in the stroma of the erythrocyte, takes up and gives off oxygen as readily as if it were dissolved in the plasma. If the hemoglobin were in solution in the plasma, the osmotic pressure of the plasma would be so high as to upset the normal fluid balance. The erythrocyte is of such size and shape as to provide optimum conditions for gaseous interchange in the lungs and in the tissues.

The circulating portion of the erythron may well be thought of as an endless chain conveyor which, in different clinical conditions, carries cups of varying sizes containing varying amounts of hemoglobin. (Figure 2). The containers or cups travel constantly from lungs to tissues and back again to fulfill their function as oxygen carriers. The absolute and the relative amount of hemoglobin in each cell or cup can be measured just as the actual and relative volume of each container can be calculated. The hemoglobin content per cell is calculated from the hemoglobin in grams per hundred cubic centimeters divided by the number of cells in a hundred cubic centimeters of blood. The amount relative to normal is shown by the color index calculated in the usual way. This index, however, does not tell how full of hemoglobin the cells are.

The degree of filling of the cells or the cups of the conveyor by hemoglobin is shown by another index, known as the saturation index. This is simply calculated for the total mass of cells by dividing the number of grams of hemoglobin per hundred cubic centimeters by the number of cubic centimeters of cells in the same amount of blood. It is apparent that the same result is obtained by dividing the hemoglobin content of the mean cell by the volume of the mean cell or the volume index by the color index.

The determinations described are all simple and are done easily and quickly by a well trained technician. The technique and the calculation are as follows:[2] Blood (10 c.c.) is withdrawn from a vein and 10 c.c. of this is run into a graduated centrifuge tube containing 2 c.c. of 1.4 per cent (isotonic) sodium oxalate and is centrifuged at high speed for one hour. To the remainder is added a drop of saturated potassium oxalate. The red cell count is made on this specimen and the hemoglobin is estimated in grams, or in per cent provided 100 per cent on the hemoglobinometer equals the hemoglobin content of a specimen of blood with 5,000,000 normal red cells per cubic millimeter. The calculation of the data is best illustrated by an example:

1. *Hematocrit reading* of blood X after centrifuging 10 c.c. of blood for one hour = 2.7 c.c. or 27 c.c. packed cells per hundred cubic centimeters of blood.

The normal hematocrit reading with a red cell count of 5,000,000 is 45 c.c. so the hematocrit reading of blood X is 60 per cent of normal.

2. *Hemoglobin content* of blood X is 7.7 grams per hundred cubic centimeters. The hemoglobin content of a normal blood containing 5,000,000 red cells is 15.4 grams, so the hemoglobin of blood X is 50 per cent of normal.

3. *Red cell count* of blood X is 3,750,000. The normal red cell count is 5,000,000 so the count of blood X is 75 per cent of normal.

4. *Volume index* (or the volume of the mean

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cell or cup of the conveyor relative to normal) is calculated by dividing the hematocrit reading in per cent of normal by the red cell count in per cent of normal.

The volume index or relative volume of the conveyor cup of blood X is 60/75 = 0.80, or 80 per cent of normal.

5. *Color index* (or the hemoglobin content of the mean cell or cup of the conveyor relative to normal) is calculated by dividing the hemoglobin in per cent of normal by the red cell count in per cent of normal.

The color index or relative hemoglobin content of the conveyor cup of blood X is 50/75 = 0.67 or 67 per cent of normal.

6. *Saturation index* (or the hemoglobin content per unit volume of cell or the extent of filling of the mean cell or cup of the conveyor relative to normal) is calculated by dividing the hemoglobin in grams or per cent of normal by the hematocrit reading in cubic centimeters or per cent of normal.

The saturation index or extent of filling of the conveyor cup of blood X is 50/60 = 0.83 or 83 per cent of normal.

The volume of the mean cell in cubic microns, and the absolute hemoglobin content of the mean cell in micromicrograms can be calculated from the data given but are of much less value than the indices since we are primarily interested in the findings relative to normal rather than in absolute figures.

Normally the mean erythrocyte is a certain size and holds a constant amount of hemoglobin. Such normal cells we designate normocytic and normochromic. Each normal cell or cup of the conveyor is filled with hemoglobin as shown by the normal saturation index. If the cell is not completely filled, or contains less than the usual quantity of hemoglobin by reason of being smaller than normal and thus is unable to carry the normal amount, it is hypochromic.

A hypochromic anemia may then be one in which (1) the cells are larger than normal but are not completely filled with hemoglobin—the volume index is high and the color index is lower (for example, V. I. = 1.50; C. I., 1.20; S. I., 0.80; showing that each cell is only 80 per cent filled with hemoglobin although each cell contains more than the average amount of hemoglobin); (2) the cells are of normal size, but the hemoglobin is deficient—the volume index is 1.00 and the color index is less (for example V. I. = 1.00; C. I. = 0.80; S. I. = 0.80; again showing that each cell is only 80 per cent filled with hemoglobin and contains only 80 per cent of the normal quota of hemoglobin); (3) the cells are less than normal and thus are necessarily deficient in hemoglobin, since hemoglobin can not be present without stroma to contain it (for example, V. I. = 0.80;

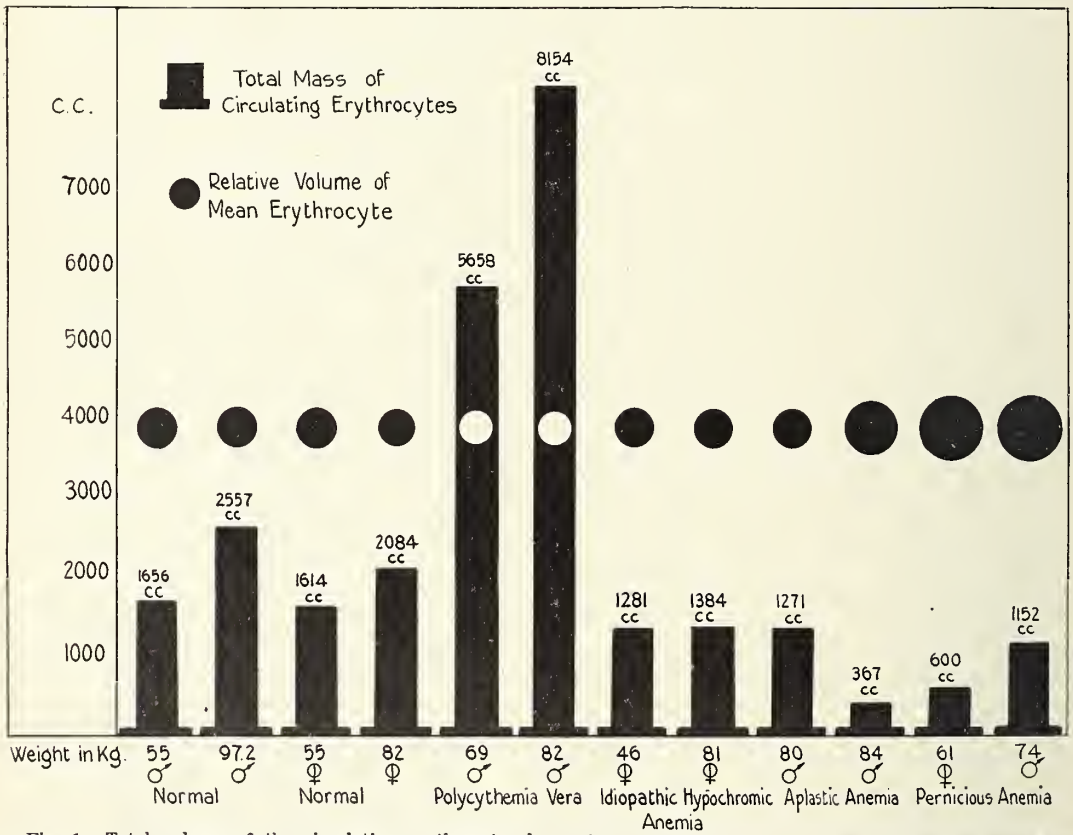


Fig. 1. Total volume of the circulating erythrocytes in various blood dyscrasias. These figures are calculated from total blood volume determinations and hematocrit readings. The diameter of the circle indicates the relative volume of the mean erythrocytes in each case.

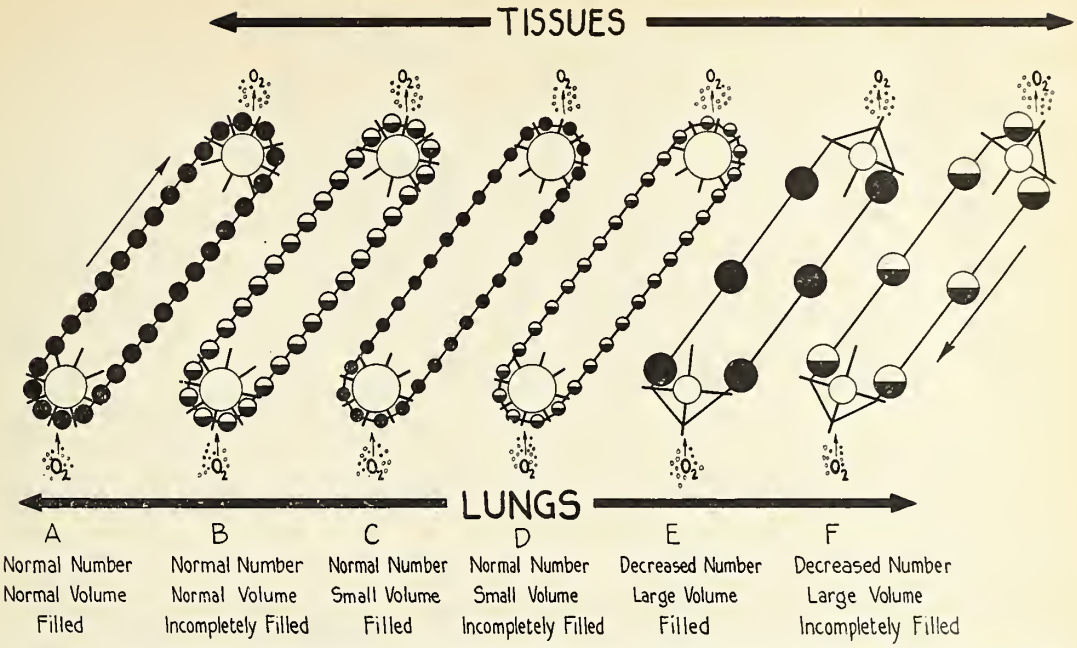


Fig. 2. A mechanistic conception of the circulating portion of the erythron in which the red cells are indicated as units of an endless chain conveyor. The relative number and size of the cups (erythrocytes) are based on determinations in actual clinical cases.

A—Normal; B—Normocytic and hypochromic anemia (low saturation index); C—Microcytic and hypochromic anemia (normal saturation index); D—Microcytic and hypochromic anemia (low saturation index); E—Macrocytic and hyperchromic (normal saturation index); F—Macrocytic and normochromic (low saturation index).

C. I. = 0.80; S. I. = 1.00 showing each cell contains only 80 per cent of the normal quota of hemoglobin, but each is only 80 per cent of the normal volume so is completely filled).

I have illustrated these different types in figure 3. Since the color index shows the hemoglobin relative to normal, the anemia is hypochromic if the color index is less than 1.00. If the cells are large and not completely filled with hemoglobin, the anemia is likewise hypocromic although the color index may be 1.00 or more. In clinical practice most of the hypochromic anemias have a color index of less than one. This is equivalent to saying that the cups of the endless chain conveyor are usually of normal size but incompletely filled with hemoglobin or are small and thus unable to carry the normal complement of respiratory pigment.

The number of cells in such conditions varies greatly. It is apparent that the number must be decreased if the cells are larger than normal and this is the usual finding in pernicious anemia. In some of the most marked hypochromic anemias with small cells there is seldom much decrease in number and often an actual increase. It is rare to find small cells filled with hemoglobin so it seems most probable that the microcytosis develops secondary to the decrease in hemoglobin since there is no need for stroma if no hemoglobin is present for it to carry.

Since hypochromia is almost entirely a problem of hemoglobin content, various phases of hemoglobin metabolism must be considered. Hemoglobin is constantly being built up and destroyed. This ebb and flow normally takes place at such a rate as just to keep the cells filled with hemoglobin. The only index of hemoglobin formation is the level of hemoglobin in the blood. There is no sensitive indicator such as the reticulocytes which reflect quickly an increase in formation of erythrocytes. As hemoglobin is broken down, iron is split off and bile pigments are formed. Normally, just enough hemoglobin is being destroyed to maintain an icterus index of 4 to 6. If the pigment increases in the blood plasma we know more hemoglobin than normal is being destroyed, provided there is no biliary obstruction. Here the increased icterus index is a gauge of hemoglobin loss. Likewise if less hemoglobin than normal is being destroyed as we often see in an extreme hypochromic anemia, the icterus index is much lower than normal so the plasma is often almost as clear as water.

For the formation of hemoglobin an adequate supply of iron and other building materials must be available and the mechanism of synthesis must be undisturbed. Every hypochromia is due to a deficiency in supply or utilization. In certain instances, such as malnutrition, all building stones may be deficient, or the pigment complex may be lacking at times. In most instances, however, iron is the deficient substance. There is only a small reserve supply of iron in the body; iron is frequently lost mechanically through hemorrhage,

the diet is frequently deficient in iron, the absorption of iron from the gastro-intestinal tract is much influenced by conditions such as the diminution or absence of free hydrochloric acid in the gastric contents, and the utilization is frequently impaired by infection, malignancy and other factors. The most important factors, however, are excessive loss of iron and deficient intake. Other elements in the hemoglobin molecule can be synthesized in the body and are usually stored in adequate reserve amounts. Relatively little is known about the site of formation of hemoglobin and the organs concerned in the process. Probably the liver, spleen, kidney and marrow are all concerned.

Whipple[3] and his coworkers have shown the marked qualitative differences in the capacity of different types of food to form blood, although he has not separated the effect on cells and on hemoglobin. The major role of iron as a deficiency factor is well shown by the regeneration of hemoglobin following a severe anemia, in which the blood lost from the circulation by hemorrhage is retained in the body, as in an intraperitoneal hemorrhage from a ruptured tubal pregnancy. The hemoglobin here is broken down, and the pigment complex and the protein is probably not used again. The iron, however, is conserved and utilized again and so regeneration of hemoglobin is usually rapid if there are no complicating factors.

The same thing happens in an anemia due to excessive hemolysis. Here there is no iron deficiency and if the cause of the hemolysis is removed, regeneration is rapid. In an untreated case of pernicious anemia, hemolysis is active and excessive as shown by the increased icterus index. This is due to the inability of the erythrocytes in the marrow to mature as a result of a lack of the maturation factor supplied by liver or liver substitutes. The erythrocytes, as a result, disintergrate in the marrow and an excessive amount of bile pigments is formed from the hemoglobin set free.

The problem is quite different, however, if blood is discharged from the body as a result of hemorrhage. Here the iron is a total loss and if the hemorrhage is large or long continued an iron deficiency and hypochromia quickly develop. The formation of hemoglobin is a vital chemical process influenced by many factors. Cancer, infection, and toxemia markedly influence the absorption and utilization of iron and other substances necessary for hemoglobin formation. The effect of such an interference is especially evident when there is a deficiency which is being supplied orally or parentally. In case of an infection, the necessity of supplying added amounts of insulin in diabetes or liver extract in pernicious anemia is well known. This need for a larger supply must be due to defective absorption and utilization of the lacking substance in the presence of infection.

The different causes of hypochromic anemia may be thus classified:

1. *Excessive mechanical loss of iron* from the body as in menorrhagia, peptic ulcer, or hemorrhoids.

2. *Insufficient intake of iron* as on an exclusive milk diet or in malnutrition from a generally deficient diet.

3. *Insufficient reserve supply of iron* and other building materials to form hemoglobin with very rapid regeneration of stroma such as takes place in the treatment of pernicious anemia.

4. *Toxic states* in which the absorption and utilization of iron and other substances are interfered with. The anemia of chronic nephritis is a classic example of this group.

5. *An idiopathic defect in absorption and utilization of iron* and other hemoglobin building stones from the gastro-intestinal tract. The absence or decrease in hydrochloric acid is an important factor here. Often there is no apparent cause.

The questions to be answered in regard to hemoglobin building materials in every case of hypochromic anemia are: 1. Has the intake been deficient? 2. Has the loss been excessive? 3. Has the absorption and utilization been *interfered* with by some intercurrent disease or without apparent cause?

In the treatment of hypochromic anemia, distinction must be made between the three groups of anemia due to excessive loss, deficient intake and impaired absorption and utilization. The blood picture in all groups is the same. If the anemia is caused by excessive blood loss, it is most important to stop the loss. The anemia will respond rapidly to adequate iron and dietary therapy in any event, however. If the intake is deficient, the provision of an adequate supply of iron and other elements quickly relieves the anemia. If absorption and utilization are interfered with in the presence of an otherwise adequate supply, little is gained by adding more building materials. Here the important thing is removal or relief of the cause. All too often, as in chronic nephritis, this can not be done. In cases with some idiopathic defect in absorption or utilization, designated chronic idiopathic hypochromic anemia, the defect can be compensated for by providing constantly an excessive supply of iron and from this, sufficient is absorbed to maintain a normal hemoglobin level.

In every case of hypochromic anemia an adequate diet and an adequate amount of iron should be supplied and any known cause of the deficiency should be removed, if possible. Any patient with hypochromic anemia due to excessive loss, insufficient intake, or idiopathic deficiency in absorption or utilization, if treated properly, will respond satisfactorily. The results of dietary and iron therapy in which absorption and utilization are interfered with by some toxic state are

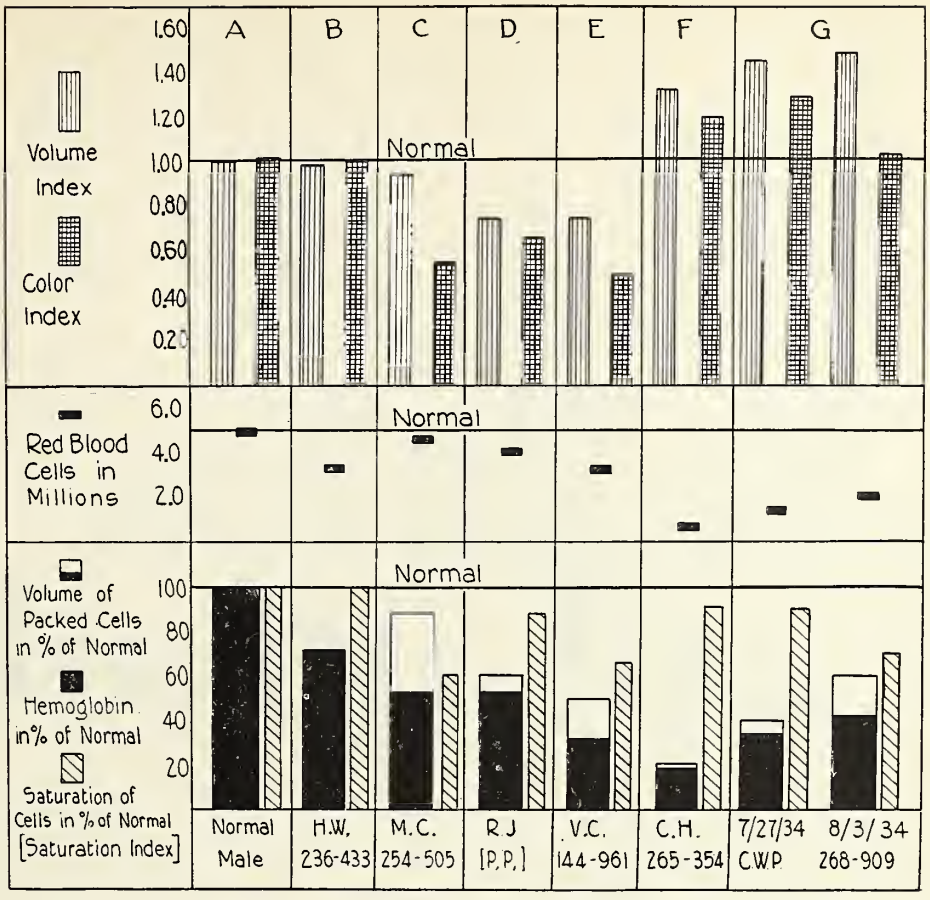


Fig. 3. Combination of indices in cases of anemia to show the different types of hypochromic anemia. Any anemia is hypochromic: (1) if the mean cell volume (volume index is less than the lower limit of normal) as indicated in D and E; or (2) if the relative amount of hemoglobin is less than the mass of cells (C and A), regardless of the size of the cell or the color index.

usually most unsatisfactory since the cause so often continues active.

An excellent diet for simple anemia is as follows:

DIET IN ANEMIA

The important part of a diet for anemia is liver, other meats, vegetables and fruit. Other foods are added to complete the diet and supply calories, but should be taken only after the patient has already eaten the necessary foods.

Take each day

1. *Meat.* A liberal portion each meal from the following list:

Liver. Roast lamb or beef. Kidney. Steak. Lamb or mutton chops.

At least half a pound of liver should be eaten every day.

2. Vegetables. Any two of the following vegetables in liberal amounts for both noon and evening meals:

Spinach	Cucumbers
Asparagus	Cauliflower
Greens	Radishes
Carrots	Celery
Squash	Beets
Sauerkraut	Mushrooms
Leeks	Peas
Pumpkin	Lettuce
String beans	Tomatoes
Cabbage	Turnips
Brussels Sprouts	

Lettuce, spinach, cabbage, tomatoes and asparagus are especially desirable.

3. *Fruits.* Take one from the following list with each meal:

Oranges	Raisins
Strawberries	Prunes
Apricots	Blackberries
Pineapple	Apples
Grapefruit	Peaches

Apricots and peaches are especially valuable.

4. *Bread, potato and cereal* may be taken in limited amounts such as three to four slices of whole wheat bread, one medium sized potato, and one small serving of cereal. Other starchy foods

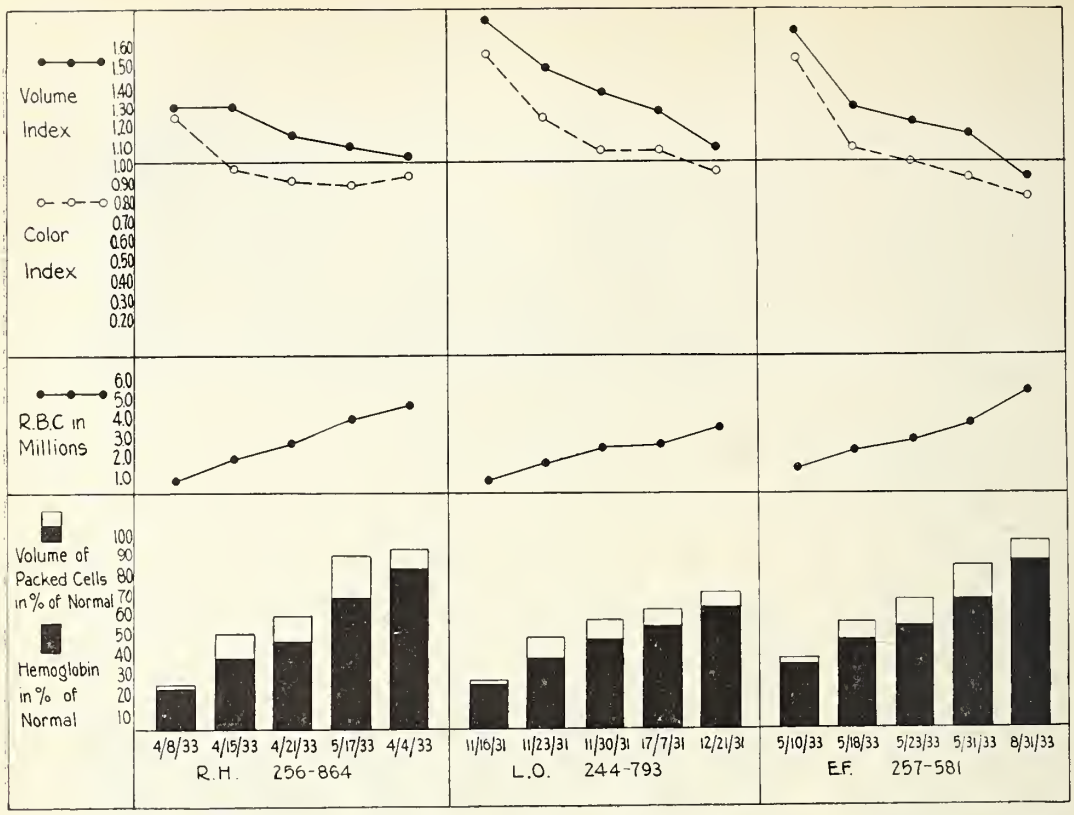


Fig. 4. Patients with pernicious anemia showing a rapid response to treatment as indicated by the return of the volume index to normal and the marked increase in the volume of packed cells. The increase in hemoglobin does not keep pace with the increase in cell mass so a hypochromia develops. There is usually sufficient reserve store of iron in the hypochromia of pernicious anemia to supply the need.

such as rice and macaroni should be taken sparingly.

5. *Eggs.* One.

6. *Beverages.* One glass of milk may be taken. Tea and coffee are allowed as desired.

7. *Butter and salad dressings* are allowed in sufficient quantities to make the food palatable.

8. *Desserts* should be taken sparingly and preferably as stewed fruit or fruit jelly.

9. *Avoid:* (a) Fried foods; (b) excessive use of salt, sugar and sweet foods; (c) fats except as included above.

In prescribing iron in hypochromic anemia the most important thing is to give enough. The type of iron used matters little provided the amount is adequate. It is seldom necessary to give iron parentally. It is much more economical to give it by mouth and usually an equally satisfactory response is obtained. I prefer to give Blaud's pills in 20 grain doses three times a day. Regeneration of hemoglobin is somewhat more rapid if 90 grams are given each day but the end result is no better than with the smaller dose. Iron and ammonium citrate are equally as good if given in 30 grain doses three times a day.

If the iron deficiency is due to hemorrhage, the iron may be omitted when the hemoglobin has returned to normal provided the diet includes a normal amount of iron. In idiopathic hypochromic anemia, a very common disease of women, iron medication should be continued permanently, since the deficiency in absorption or utilization seems a permanent one. A very satisfactory procedure is to give iron in full dosage for one week of each month after hemoglobin has returned to normal. In this way the deficiency is supplied and a recurrence of the anemia is prevented. As a rule iron therapy is not indicated in pernicious anemia as the reserve supply is adequate. If the volume index is not very high the icterus index is low before treatment or if the response to specific therapy results in a very rapid increase in erythrocytes, a hypochromia usually develops. (Figure 4). In such cases iron should be given.

In looking for causes for a chronic hypochromic anemia, the history of excessive blood loss at the menstrual periods, of long continued bleeding from hemorrhoids, a deficient diet taken over a protracted period, or repeated pregnancies will often give a clue. The stool should always be tested for occult blood, as much blood may be lost through the intestinal tract without being grossly apparent to the patient or physician.

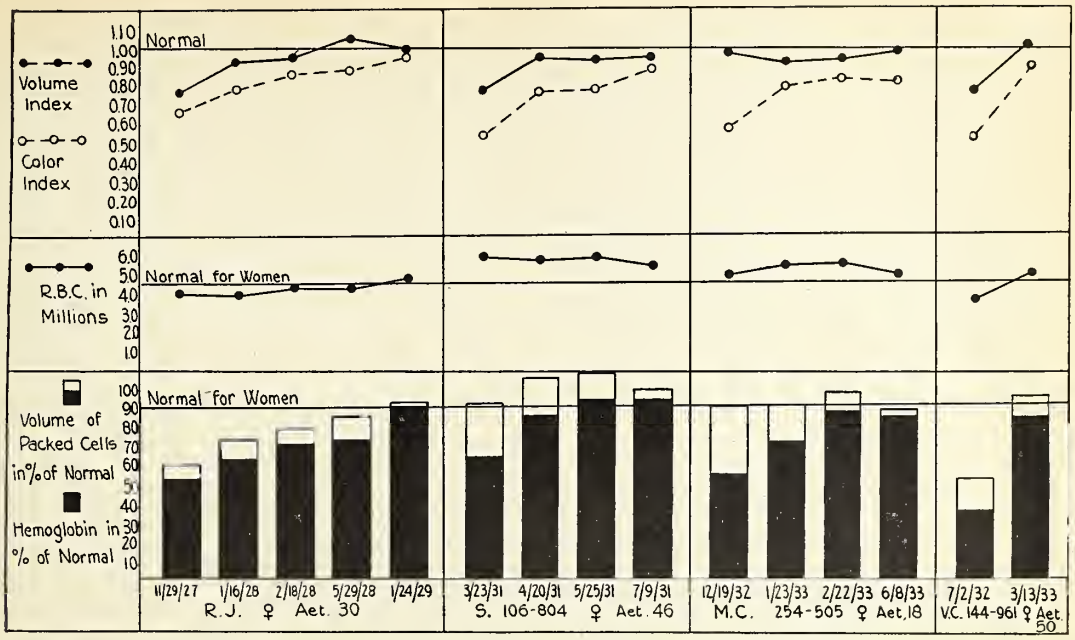


Fig. 5. The response of hypochromic anemia to adequate iron therapy. In cases 2 and 3 the amount of cells is normal but the hemoglobin is deficient; in cases 1 and 4 both the cells and hemoglobin are lacking.

Chronic nephritis as a cause of anemia is frequently overlooked. The anemia may be all out of proportion to the signs of kidney disease. Hypothyroidism, lead poisoning, malignancy, especially of the ascending colon and stomach and concealed infection may be causative factors in a puzzling case of anemia.

If the anemia is marked and the therapy adequate, hemoglobin regeneration usually takes place at the rate of about 1 per cent a day. The results of complete treatment are illustrated in figure 5. I see no value in adding copper, cobalt, vitamins and the many other things proposed if the diet is adequate and sufficient iron is given. The many shot-gun mixtures offered for the treatment of anemia are much to be deplored. There is not enough of any one potent ingredient in most of these to be of real value. The value of liver extract and other liver substitutes in the treatment of hypochromic anemia is still unsettled but these probably help little if any. The one exception to this statement may be the idiopathic hypochromic anemia with achlorhydria. If liver is included in the diet, however, it is doubtful if the use of liver extract, even parentally, will help much. If it is imperative to speed up hemoglobin regeneration as in preparation for an operation, transfusion is indicated. In certain other instances also transfusion is most valuable.

Little has been said about the regeneration of red cells in hypochromic anemia. Often these are already within normal limits although they may be smaller than normal. If below normal in number they will return to the proper level; if below normal in size, the cell volume will return to normal with the use of the measures outlined for the regeneration of hemoglobin.

SUMMARY AND CONCLUSIONS

I have described the viewpoint of the circulating erythrocytes, the reserve store, and the red cell forming tissues as an organ, designated by Boycott as the erythron.

The erythron is normally made up of cells remarkably constant in size and shape whose function is to act as containers for the respiratory pigment, hemoglobin, in its circuit from lungs to tissues and back again.

From a mechanistic standpoint the system is best thought of as an endless chain conveyor, with buckets (red cells) of a certain size and fullness.

By proper laboratory studies the relative mass of cells and hemoglobin, the volume of the mean cell, the hemoglobin per cell and the extent of filling of the cells with hemoglobin are easily determined.

Normally the cells are of a certain size and are filled with hemoglobin and so the color index is 1.00. If the color index is less than 1.00 the cells are spoken of as hypochromic since the quota of hemoglobin per cell is less than normal. In such a case the cups of the conveyor may be of normal size but only partly filled, or the cups may be small and more completely filled. The quota of hemoglobin per cell in reference to normal is indicated by the color index; the extent of filling of the cup or cell is shown by the saturation index.

The color index may be normal or even increased and yet a hyperchromia be present. This occurs if the increase in cell volume is greater than the increase in hemoglobin quota so the cell is again not completely filled and the saturation index is lower than 1.00.

Every hypochromic anemia is due to (1) an excessive external hemorrhage, by which hemoglobin building materials are lost from the body, (2) to an inadequate intake or supply of building materials in relation to need, or (3) to impaired absorption or utilization. Iron is the major and important deficiency. The reason for deficient absorption and utilization may be apparent (malignancy, infection, etc.) or be cryptic (idiopathic hypochromic anemia).

The treatment of hypochromic anemia requires an adequate diet, sufficient iron, and removal of the cause of the blood loss or interference with hemoglobin metabolism if such be possible.

The results of the proper study and therapy of hypochromic anemia are usually most gratifying to both physician and patient.

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DISCUSSION

A. B. BROWER, M.D., Dayton, Ohio: Various blood diseases fluctuate greatly in frequency as the result of unknown causes. Chlorosis in the past was one of the common forms of anemia. The cause of its practical disappearance is one of medicine's mysteries. Within the past two years two blood diseases appear to be on the increase—idiopathic microcytic anemia, which occurs in women of middle age, and agranulocytic angina.

We are hearing more of macrocytic or hyperchromic anemia or those in which we have a deficiency of the specific anti-anemic factor and in contrast we have microcytic or hypochromic anemia in which we have iron deficiency.

An insufficient amount of iron from hemoglobin formation leads to hypochromic or secondary anemia. The most common cause is continued or recurrent loss of blood. This gradually exhausts the body's reserve of iron.

Increasing interest is being paid to anemia occurring frequently in middle aged women. Hypochlorhydria or achlorhydria is invariably associated in this state. The anemia is apparently due to an inadequate absorption of iron, depending upon the lack of acid in the stomach. Normal persons conserve their iron so well, or the requirement of food iron is so small that unless some other factor as hemorrhage or pregnancy is present they seldom develop anemia. Menstruation may be enough to cause anemia in some women who have hydrochloric acid deficiency.

It is interesting to know that a series of cases of idiopathic hypochromic anemia studied by Mettier, Kellogg and Rinehart revealed that practically all of the women investigated had diets for years deficient in meats, fruits and green vegetables. These patients with three exceptions were of normal weight. The one constant characteristic of the diets was a lack of iron containing foods. This is stressed because in these days when so many women patients are curtailing their diets to restrain their weights severe anemia often results. The matter of diet should be studied during the course of observation of a patient suffering with hypochromic anemia.

The symptoms found in patients with hypochromic anemia are exhaustion, faintness, dizziness, palpitation, fatigability, shortness of breath, pallor, tachycardia, hypotension and often dependent edema. An occasional patient will complain of difficulty in swallowing. Not infrequently the patients have symptoms analagous to those patients having pernicious anemia. Glossitis, digestive disorders, flatulence, alternating constipation and diarrhea are symptoms often complained of. A few patients may complain of numbness and tingling without any changes demonstrable in the nervous system. Hypochromic anemia and pernicious anemia are occasionally associated. The anemia may be relieved but not entirely corrected by liver therapy. These cases will show further improvement if given adequate dosage of iron.

In the treatment of hyperchromic anemia it is well to remember that the red cell regenerates more rapidly than the hemoglobin. The response to treatment can be evaluated by improvement in clinical signs and symptoms and in the blood changes. Earlier effect is commonly an increase in percentage and concentration of reticulated red blood cells.

There should be no great dispute over the type of iron in the treatment. The important thing is the amount. Adequate dosage must be given. There is absolutely no basis for routine hypodermic administration of iron. The more simple one can make the therapy usually the more effective it is. Iron may be given parenterally but the distinctly effective daily dose (16-32 mg. of iron in form of iron citrate) is close to the toxic dose.

Generally patients with acid gastric secretion respond more promptly than those who have achlorhydria. Patients with achlorhydria require larger dosage and continuous treatment with iron to prevent recurrence. Whipple says, "Secondary anemia in direct contrast to pernicious anemia is a disease in which there is a deficit of hemoglobin and related pigment". Minot and Patek in working on this implication have found that some cases of hypochromic anemia not responding to iron alone will promptly improve when bile pigment was fed in addition to iron. It is not uncommon to find a severe hypochromic anemia associated with arthritis, especially of the atrophic type. It is important in the treatment of arthritis not to overlook this anemia and frequently the patient's general well being is aided materially by correcting the anemia. In certain liver conditions, especially cirrhosis of the liver, anemia is often a troublesome factor. Iron plus bile pigment will be of marked value, whereas iron alone in this particular type of case will not suffice.

Many cases with achlorhydria are made more comfortable by use of large doses of hydrochloric acid in connection with the iron therapy. Attention is called to the treatment of myxedema. In many of these cases severe hypochromic anemia exists. Thyroid plus large doses of iron will give

a prompt response. The use of thyroid alone is often attended by slower results.

In the hypochromic anemia of pregnancy, readily alleviated by iron, one may correlate the degree of the anemia with the degree of gastric hypoac'dity and the quality of the diet. Infants born with a normal blood, at the age of one year, will often have an anemia in proportion to the anemia of the mother at time of their birth. This may be due to an insufficient supply of iron in utero, yet not enough to cause anemia at birth. This condition should be and can be easily prevented by proper treatment of the mother during pregnancy.

AUGUSTUS A. HALL, M.D., Columbus, Ohio: I wish to discuss this paper from the standpoint of the periodic health examination and show with the brief illustration of a case that some of these hypochromic anemias may be arrested early.

About a year ago a woman, aged 55 years, came into the office requesting a 'check-up'. Her only volunteered complaints were slight shortness of breath on exertion and ready fatigue. A mild hypochromic anemia was discovered and on further examination a bleeding cervical polyp was found. This was eventually removed, iron administered, and complete recovery resulted.

If this woman had received a periodic examination earlier the anemia might have been prevented altogether.

CHRONIC NASAL SINUSITIS:

The Evaluation of Opaque Oils in Diagnosis and Treatment. Some Surgical Observations and Results

By HENRY M. GOODYEAR, M.D., CINCINNATI, OHIO

IN chronic nasal infections an antrum usually represents the "master sinus". Its large size, early appearance, dependent drainage, and apposition to the teeth make it the most vulnerable of the paranasal cavities.

Once an antrum becomes infected its secretion rapidly invades the other sinuses, especially the ethmoids and frontal on that particular side. One would rather expect such an extension on considering pus draining from the antrum into the middle meatus where, in the recumbent position, it must lie in contact with the mouths of the ethmoid cells and frontal sinus.

On many occasions after injecting opaque oil into an antrum, at *X*-ray I have found the oil in the ethmoid[1] region and not infrequently even in the frontal[2] sinus. This being true, it is logical to suspect that pus will also migrate from the antrum to the neighboring sinuses. I have also been impressed with the rapid relief of ethmoid infections where an antrum has been treated surgically even though the ethmoid cells were not exenterated.

More careful histories will also reveal how frequently the extraction of an infected tooth marks the onset of nasal or general symptoms of which the patient complains, even though a sinus infection is not suspected.

I shall cite two recent cases to illustrate this point:

One, a young woman, complaining of pain in the finger, wrist, and knee joints. Upon examination I noticed the right upper second bicuspid was absent. It had been extracted eight years before at which time, as the patient recalled, there had been some trouble in getting the socket to heal. Upon questioning, it was learned that some fullness of the nose and post-nasal dripping began at this time and had continued. Also mild joint pains appeared that same year. Upon examination of the nose there were no important findings. A roentenograph with opaque oil showed a distinct filling defect in the right antrum and granulations with a small amount of pus were found at operation.

The second case, a woman, age 52, with arthritis for two years. Again the absence of an upper tooth in spite of negative findings led to a history of extraction five years previous at which time some swelling occurred over the antrum. Following there had been considerable post-nasal dripping and occasionally perverted smell. A roentenogram demonstrated a filling defect in the antrum on the side of the extracted tooth and at operation fetid pus and diseased tissue was found.

In neither of these cases did the history indicate that an opening occurred into the antrum at the time of extractions. They represent what frequently occurs when a dead tooth is permitted to remain in contact with the floor of the antrum. Any dead tooth in this position is a menace and should be removed for the safety of the health of the patient. This is especially true of the upper molars which have three roots, only, two of which are usually evident in roentgenographs.

Many dentists do not realize the importance of immediate closure of an antrum fistula occurring at the time of extraction, and the slogan should be, *never irrigate an antrum, not even a single time through a canine fistula as a therapeutic measure.* A suture at this time would be more helpful, and by all means *the blood clot should not be disturbed by any solutions whatsoever.* Avoid suction and respect the saliva which possesses certain inherent qualities that are germi-

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cidal, promotive to healing, and a most effective coagulent[3] when in contact with blood.

If irrigations should be necessary later it is better that they be done through the nose, the normal site of drainage for an antrum. If the sinus is already chronically infected the fistula will be slow in closing and even as a most conservative measure a large opening should be made through the inferior meatus into the antrum. This procedure is comparatively simple, can be done quickly, in the office, and in my experience has been highly satisfactory.[4]

Dental fistulas which close after months or a year without surgical opening through the nose almost without exception leave the antrum chronically infected for life as is often evidenced by a disturbance with each succeeding acute rhinitis.

Many dentists procrastinate after an accidental loss of a piece of tooth into an antrum picturing a radical operation through the canine fossae as the only means of recovering the fragment. While, as a matter of fact, the offending body can be removed quickly and without great shock by an opening through the inferior meatus of the nose without hospitalization or unnecessary embarrassment to the dentist

I use opaque oils routinely in the roentgenographs of all suspected antra and sphenoid infections. The oil is injected through a double curved cannula through the normal ostium of the antrum in most cases, and usually through the mouth of the sphenoid with a simple cannula[2].

The frontals may be injected and rayed in the knee chest position; a position which I advocated some years ago[2].

For ethmoids I depend upon the regular roentenograms, intranasal findings, and the clinical history, rather than a displacement filling with opaque oils. Lack of filling may or may not be indicative of a pathological process.

I am rather opposed to frequent daily antrum irrigations. If an antrum does not show good response, as indicated by the character of the washings after four or five irrigations at three or four day intervals, 2 cc. of iodized oil is injected. Seven to ten days later any oil remaining is removed by washing, and it is surprising how frequently a marked improvement is evidenced, often by a small quantity of bright canary yellow pus, or a small round globule of pus and oil. I have had some very excellent results by using the iodized oil after the first irrigation and repeating the oil a week or ten days later.

Slight persistent iodine therapy is not without virtue.

Frequently I find patients with prolonged bronchial coughs who get almost immediate relief from the injection of iodized oil into an antrum. I have had a few cases of bronchial asthma and hay fever, which have responded well to the iodized oil injections.

The use of iodized oil (27 per cent) in the treatment of retrobular neuritis came to my attention incidentally after injecting a sphenoid for the purpose of a roentgenograph. To my surprise the vision cleared within 36 hours. Since we are not sure just how opening the sphenoid and posterior ethmoid cells helps these cases, further trial may prove that the iodized oil will produce the same good and unexplained reaction.

Surgically I have found no external frontal sinus operation which has proved uniformally satisfactory. I prefer the so-called Lynch operation but even the largest opening into the nose frequently closes. I had the pleasure recently of seeing Dr. Sewall demonstrate his ingenuous method of turning a mucus membrane flap into the naso-frontal opening, and he is hopeful that this rather technical procedure will solve the problem of keeping the frontal open.[5]

When an intranasal frontal opening can be made by removing the anterior ethmoid cells and entering the frontal sinus with a Pratt curette without curetting anteriorly, I have found that these openings tend to remain. I have discarded entirely the use of any anterior frontal sinus rasphe which produces granulations and fibrous tissue, outweighing any accomplished good.

Acute suppurative frontal sinusitis, which does not show improvement and good drainage from the nose, demands immediate relief from pressure. A small trephine opening at the junction of the anterior and inferior walls without any attempt to probe the cavity will often suffice. A small rubber tube may be inserted but should not touch the posterior wall. Daily saline irrigations are indicated. The wound closes with little scarring and further surgery is not usually required. This is especially true of children.[6] Trephining causes much less trauma in the infected area than intranasal operations.

In chronic ethmoid infections in young adults let us look especially to allergic conditions, hypothyroidism and septal obstructions. I rarely open the ethmoid cells in a young person at the time of a septum operation. The middle turbinates are broken medially and, if a cystic cell is present in the middle turbinate, its lateral wall is removed. General treatment, the use of iodine internally, small doses of thyroid, and attention to a possible allergy give these patients the greatest relief. The exenteration of the cells should be deferred as an extreme measure.

I am convinced that we do radical Caldwell-Luc operations on many antrums that would respond more kindly to an intranasal operation; an operation that has been greatly neglected due to the type of opening that is usually made. The inferior turbinate should be elevated (not removed) and the opening into the antrum should be cut *far back*, by using a *straight* shaft *downward cutting sphenoid forceps*[4] and the opening lowered

toward the floor with a curved downward biting forceps. The entire cavity should be packed with iodoform gauze (5 per cent) and the gauze permitted to remain for four to ten days until it softens with secretion. Thus treated I have observed some of these cases over a period of six years and the results have been excellent.[4]

556 DOCTORS BUILDING.

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DISCUSSION

HUGH GIBSON BEATTY, M.D., Columbus, Ohio—Chronic maxillary sinusitis always interferes with the patients health in one way or another. Chronicity always requires more than ordinary means of diagnosis and treatment. Adequate ventilation and free drainage are the mildest forms of treatment among those that *must* be instituted. When confronted by a chronic maxillary sinusitis, we always attempt to identify one of three types:

1. Thickened degenerated lining (with or without allergy).

2. The chiefly purulent type, with possible bone change.

3. Either of the above with malignancy.

As Dr. Goodyear has said, a careful history and *X*-ray with opaque oil will help us greatly here. We must be constantly on the watch for constitutional disturbances, such as the Doctor has mentioned, which may cause an engorgement and edema of the sinus lining, especially so in considering radical surgery. It is a great rhinological blunder to do a radical operation on a maxillary sinus when an adequate intranasal operation would suffice. Equally out of place is the minor operation in the presence of malignancy.

Dr. Goodyear has criticized, in his characteristic gentlemanly way, the lack of respect some dentists show the antrum. We are sure he would be willing to add to the guilty list "some internists, general practitioners and surgeons".

This action on the part of this group is activated either by a sad lack of good judgment or inadequate training.

We are interested in the Doctor's results had by leaving the oil in a sinus for several days; both as to its curative effect on a sinus in itself and its secondary effect on retrobulbar neuritis. As the Doctor says, "Slight persistent iodine therapy is not without virtue". We have been led to believe that iodized oil was more or less inert as a medical agent in the lower respiratory tract and possibly this is because it is so soon expelled.

Whatever the method employed, we know that prompt depletion of the congested adjacent sinus lining is necessary in secondary sinus inflammation of the optic nerve. If it can be done without surgery, so much the better for the sinus—which we do often find on opening—free from pus and polypoid degeneration. However, prompt and permanent improvement in the vision have so far justified the surgical procedure.

In frontal sinus surgery, our results depend *so* much upon the anatomical configuration of the sinus itself, the intranasal cavity and the anterior ethmoids. Like Dr. Goodyear, we have found no one operation suitable to all cases, either total obliteration of the sinus (if possible) or adequate intra-nasal ventilation and drainage is necessary. Having been trained by Halle to do his flap operation and not being familiar with the technique of Dr. Sewall, a comparison cannot be made. When the chisel has to be used to remove the anterior wall or the rasp has been used, without a flap, obstructing scar tissue will form. Flap and skin graft operations have been devised to reline the area.

We agree completely with the Doctor in his conservatism in the surgical treatment of frontal and ethmoid infections in juvenile cases. Radical surgery, we feel, has no place here except, of course, in extreme cases. Then, one must be just as radical as the disease.

Dean[1] in 1919 states, "For diagnosing the pathological condition of sinuses, radiography is very unreliable". In his latest work, Watson-Williams[2] makes the same statement. We recently opened a frontal sinus in a six year old child and found the anterior plate soft and perforated at one point—after an almost negative *X*-ray report. It is probable that many rhinologists do not use the external trephine operation early enough in cases of blocked frontal drainage. This is an important point brought before us by the writer.

It was the discussant's pleasure to sit in on Doctor Goodyear's paper on this subject at the last meeting of the American Laryngological Association and to be greatly interested in his technique for the intra-nasal antrum operation.

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—OSMJ—

New Books

Diseases of the Skin. By Richard L. Sutton, M.D., Sc.D., LL.D., F.R.S. (Edin.) Professor of Dermatology, University of Kansas, School of Medicine, and Richard L. Sutton, Jr., A.M., M.D., L.R.C.P. (Edin.) Assistant in Dermatology, University of Kansas, School of Medicine. With 1310 illustrations and 11 colored plates. Ninth Edition, revised and enlarged. Price, $12.50. The C. V. Mosby Company, St. Louis, publishers.

OUR RESPONSIBILITY TO THE NEWBORN

By STERLING H. ASHMUN, M.D., Dayton, Ohio

INFANT mortality statistics continue to show that in spite of a greatly lessened mortality throughout infancy the loss of life suffered in the newborn or neonatal period is still very high. It is the natural desire of every physician to learn why this condition exists, and to aid in lessening the morbidity and mortality of this period of life wherever it is reasonably possible.

The more one studies the factors that enter into the causes of infant mortality the more respect one has for the advancement in the practice of those branches of medicine that are the oldest of all, viz., the delivery of babies and the care of them after they are delivered. We all must realize that one reason that neonatal mortality is still high is that better obstetrics is bringing into the world, alive, babies that in former years would have been stillborn. [1]Stillbirths have been reduced in ten years from 69 to 47 per 1000, and prematures increased from 27 to 34.7 per 1000. Naturally a number of these babies, although alive at birth, cannot be expected to survive because they are still constitutionally too weak to overcome the hazards of a new environment.

The ancient Spartans probably spared few prematures, their idea was to relieve society of those for whom the struggle for existence would be too severe. We, of the twentieth century, strive to make it possible for those obviously unfit to continue to exist even though a burden to society. Yet there is no other safe attitude for the medical man, and when we recall that Robert Darwin, Sir Isaac Newton, Voltaire, and Napoleon were all prematures, we cannot fail to put forth just as great an effort to sustain the life of a weakling as we would that of a more vigorous baby. The fine response that these handicapped babies make furnishes something of a thrill to those who are responsible for their care.

Everyone who sees many newborn babies has constantly in his mind the immediate results of [2]intracranial hemorrhage and it is important that we all realize that when we speak of such conditions resulting from birth trauma we do not imply lack of skill in delivery or management of labor but that these conditions are, for the most part, wholly unavoidable. We all know that hard labors are attended by a high incidence of intracranial injury, be it hemorrhage, laceration, contusion, or edema. We also know that Caesarian section does not lower that incidence. In fact, vertex delivery with low forceps has a lower incidence of hemorrhage than does section. The fact that I wish you would note with me is that many show their first symptoms several days after dismissal from the hospital. These symptoms usually relate to the digestive or to the respiratory system. Some degree of permanent damage results in from 10 to 20 per cent of cases of intracranial hemorrhage. I do not recommend tapping of spine or cistern when baby is in shock unless there is evidence of very great pressure for often much harm is done by this procedure. In 1928, according to Ehrenfest[3], there were 89,765 stillbirths, and 83,068 deaths in the first month of life. Birth trauma is a probable factor in 36 per cent that die before labor begins, 26 per cent during labor, and 38 per cent after delivery.

Asphyxia[4] is not the cause of death but the result of birth trauma. It is astounding to know that out of 7,226 pregnancies only 51 per cent were born alive to say nothing of the pregnancies that were prevented. The prevention of asphyxia then is the prevention of birth trauma, but if trauma occurs one should watch the fontanelle and institute relief from pressure in the case of twitching, vomiting, or convulsions. The asphyxias have been clarified a great deal by Yandell Henderson[5] and yet the causes are not always easy to determine. For instance, extreme or deep narcosis may just as likely be the cause as severe compression. In fact, some of our more severe types have been noted in cases delivered by section when a preliminary narcotic was used. The treatment for asphyxia is now agreed to be the use of liberal quantities of CO_2+O, 10 to 30 per cent mixtures being preferred. If the child is in the pallid state it may be necessary to force oxygen into the cells of the respiratory center in order for them to be irritable enough to respond to the stimulation offered by the CO_2. All of us have seen them almost black from CO_2 retention yet unable to utilize that CO_2 for want of oxygen. In the pallid state I prefer a 20 per cent mixture of CO_2 with O. Henderson says that "slight oxygen deficit increases cerebral sensitivity and causes hyperpnea but a greater deficit results in lessened irritability and may even cause cellular paralysis." I like the small tent better than tracheal tubes since the use of the latter requires too much manipulation and added risk of pneumonia; laryngeal suction with the tonsil suction or soft tip rubber bulb will suffice to remove the secretions.

Flagg's Method [6 7 8] of laryngeal administration of the gas is not easily accomplished, respirators are not always available and require a technician to operate. I shall mention the methods and procedures that we use and only hope that you will

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feel free to offer suggestions that will help all of us to lessen neonatal mortality. I shall refer very little to the gastro-intestinal group of cases only to commend the use of weight loss preventive formulas during the first three or four days of life. I. Newton Kugelmass[9], et al., suggested the routine use of 6 per cent gelatin, 3 per cent dextrose, and ½ per cent NaCl. This solution shortens clotting time lessening danger of hemorrhage, and hydrates the body, lessening the initial weight loss to 1.7 per cent instead of 7 per cent. Too many are prone to forget the value of colostrum both as an intestinal gland activator and as an aid in the prevention of hemorrhage, and, of course, all observers agree that breast milk is still the best universal baby food and may be continued even into the second year with safety.

CONCLUSIONS

1. A relatively high mortality in the neonatal period is quite natural and instead of being lowered may even become greater due to better obstetrics resulting in more premature births and more babies being born at term that would, if left to natural results, be stillborn.

2. Our responsibility lies in being prepared to offer these live babies our best efforts and the results of scientific progress.

3. Every baby is entitled to a thorough examination by a physician.

4. Not every maternity needs a respirator but a simple suction apparatus and tents for administering CO_2 and Oxygen should be available to treat asphyxia and pneumonia.

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DIFFERENTIAL DIAGNOSIS OF SCHIZOPHRENIA AND SCHIZOPHRENIC REACTION-TYPES

By J. FREMONT BATEMAN, A.M., M.D., CINCINNATI, OHIO

SCHIZOPHRENIA is a disease occurring early in life, usually with an insidious onset, characterized by a generalized physiological imbalance of the nervous system and by a most bizarre type of mental activity. It is a disease in which the symptomatology has been measured purely from psychological data. A disease, which in the main, produces an extreme gutting of the personality resulting in a nomadic and distorted form of behavior. It is a disease without a single tangible scientific fact regarding its etiology.

Progress in our understanding of schizophrenia has been greatly retarded because the present researches consist of seeking physiological objectives from psychological data. If one will review the literature from the time of Haller to the present day, he will find that this has not proved very fruitful. Not one single reference can be found where any type of personality normal or abnormal presupposes a given anatomical or physiological change. It must be remembered that the original connotations, dementia praecox and later schizophrenia, were formulated irrespective of the physical state of the individual. Volumes of negative information have been added to the original conception of the disease with the result that our present day understanding remains very much the same as it was twenty-four years ago. It is hoped that sufficient physiological factors will be found to lift this disease from the mire of the psychological waste-basket, and remove it from the annals of the mysterious.

From Hunt's most interesting classification of psychological types based upon the physiological laws of excitation and inhibition, the whole domain of psychriatry might be better understood. Certainly the cortex of the brain shows varying degrees of excitability and inhibitibility and it is much more wholesome, fundamental and scientific to assume that emotional changes result from changes within the brain itself.

For the past two years there has been accumulating sufficient evidence to show the undoubted sympathetic character of various reactions which occur from stimulation of regions of the brain and brain stem. Experimental work has proved

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that the brain stem is directly in control of many of our most important physiological activities. The diencephalon assists materially in regulating body metabolism through regulation of the temperature, cardiac activity and certain known biochemical changes.

Painful impulses from the body including interoceptive, extroceptive and proprioceptive impulses reach the thalamus and apparently through thalamocortical connections register the particular affect of the individual at any one time. General sensibility is carried to the ventral nucleus of the thalamus. The thalamus is closely connected with affective experiences and with the whole domain of pleasurable and painful sensations. The affective attitude of a person may be changed by irritation of various regions of the diencephalon. The cranial division of the autonomic nervous system appears to be conservative in its effect. The third, seventh, ninth and tenth cranial nerves all have protective influences over the various parts of the body which they supply. Much experimental data have accumulated in recent years which show changes in the autonomic nervous system resulting from lesions of the diencephalon.

In the group of schizophrenic reaction-types this protective and inhibitory function of the autonomic nervous system seems to have been removed. To support this belief we find changes in the heart rate, pupillar reaction, secretion of saliva, gastric and pancreatic juices, vasomotor phenomena, etc., all of which show that the conservative effect of the cranial division has been eliminated and the protective influence removed from thoraco-lumbar activities.

In the schizophrenic reaction-type it is not determined whether it is actual excitation of the cells of origin or stimulation of the cells or origin. At any rate the cranial division of the autonomic which is inhibitory in nature is removed from its normal actions. Otherwise the pupil would not be so unstable but would contract to strong stimuli and remain contracted if the natural and normal inhibitory influences were present. The same is true with the heart rate and the respiratory rhythm.

There are certain physical findings and pharmacological studies which in general show increased vagal tone in the true schizophrenias. Of course it is easy to find individuals who have a tendency towards increased sympathetic tone and increased parasympathetic tone in any of the classical psychoses just the same as in any of the so-called normal group of people.

With so much significant experimental data available regarding the somatic and visceral afferent stimuli to the diencephalon and adjacent components of the cranial autonomic system, it would seem that a disturbed interofective mechanism was unable to adjust to the perpetual bombardments of exterofective stimuli and, therefore, result in changes, not only of the visceral afferent mechanism, but in the dynamic autonomic function of the personality as well.

Our most primitive emotions are the result of, or expression of, changes in the autonomic nervous system. Certain stimuli which may produce rage or fear in one individual will not register like effects in another. Our nervous systems react differently to different stimuli or to the same stimuli. This we see among the normal group of people who register unpleasant affects by a hyper-ideokinesia of the facial nerves. It is certainly a good thing that exterofective stimuli produce different interofective reactions, otherwise individuality would be lacking. Disturbed affects and emotions, therefore, are but outward expressions of a disturbed autonomic nervous system. Its disturbance can easily be recognized by pupillary changes, cardiac irregularities, vasomotor changes, changes of expression and changes in postural tonus. How would it be possible to recognize emotional stress if these known physiological changes did not obtain?

In the classical schizophrenic, the so-called malignant dementia praecox, we find a group who are not emotionally unstable, but who show emotional devastation. In this group the pendulum on the clock has stopped. And if we review the life history of those who later develop schizophrenia, we find that the pendulum was swinging at a very low ebb, or had stopped entirely. Therefor, as a group, exterofective stimuli produced no marked emotional changes and the pendulum remained stationary. These changes in emotional response occur early, around the period of puberty, sometimes before and sometimes a little later. They are recognized changes because the exterofective environmental stimuli do not provoke the natural emotional responses, and we see the shy, seclusive, shut-in, apathetic personality slowly developing means of escape by withdrawing into his own world of fantasy.

Why do we see schizophrenia developing in one member of a family of several children? Have environmental changes influenced the behavior in this one child and not the others? Is it possible that his power of receiving and adjusting various stimuli has been destroyed from inherent, organic, or toxic influences upon his interofective mechanisms? And what, if any, are the effects of early supra-renal involution and thymus hypertrophy? Is it not possible that the early and more malignant mental reactions are but outward expressions of lack of harmonious associations between the autonomic nervous system and the higher centers of the diencephalon, including the afferent and efferent connections with the cerebral cortex?

Whether the reaction in the malignant schizophrenia is the result of excitation or inhibition of the higher centers is still a matter of controversy. However, there is very strong evidence

to support the belief that in the true schizophrenic there is over-excitation of the cranial division of the autonomic nervous system. This group as a whole shows changes which are vagotonic in nature. The pulse rate is slow, pupils miotic, blood pressure low, oculo-cardiac reflex present, allergic reactions, absent gag reflex, vasomotor changes in hands and feet and many other symptoms referable to cranial and sacral autonomic excitation.

The term "schizophrenic reaction-type" is used to connote a very definite organic neurological syndrome associated with a type of thinking, feeling and acting which is, during the acuteness distinctly schizophrenic. The clinical features are as follows: This syndrome occurs usually between the ages of twenty and thirty-five, although it may occur earlier or later; at any rate the onset is much later in life than in the classical constitutional schizophrenic.

The onset is acute. That is to say it is sudden and in many individuals the very abrupt nature of the onset is a surprise to those around them. Psychologically the onset is very distinctive, in that the apparent internal conflicts seek expression by projecting to some unreal and bizarre external occasion. This type of onset is in contrast to the manic depressive and paranoid states, which in the main, show a gradual expression of some less bizarre internal or external occasion. The organic schizophrenic reaction-types seek protection in some way. Their ideas of unreality, suspicions, lack of interest, etc., are expressed in the form of hallucinations of any or all of the exteroceptive portals, and delusions usually of an external nature, which are concerned with inflicting some bodily harm to the patient. These delusions, although commonly of the type that would inflict immediate bodily harm, such as being poisoned, killed, etc., may seek expression in a manner which prohibits normal activity in the patient, and leads to a life of indifference and apparent unconscious rumination.

There is usually a history of one or more infectious and surgical diseases which either preceded or was associated with a change in personality. Such changes are not as prominent as we see in the classical post-influenzal encephalitis, nevertheless a careful history will show that the physical illness was accountable for the mental change or indirectly aggravated the already existing mental departure. The classical schizoid personality does not exist. There may be some evidence of a social behavior but certainly no more than can be found in the so-called normal group of people. From the standpoint of psychopathology there is insufficient evidence in their early life to warrant the belief that these people need attention and that they may later develop a mental condition.

The physical and laboratory examinations usually reveal some changes in the respiratory, circulatory and digestive systems, and occasionally the endocrine and renal systems. There is some evidence of a mild toxic state. The white blood count is elevated, the blood sedimentation usually accelerated, the pulse is rapid, the pupillary status indifferent, the blood pressure is above the normal, and the basal metabolic rate slightly increased.

The pupillary findings are the most important and constant of all. The pupil is normal in size or midratic; reacts to light and accommodation under normal stimulus, but shows a reaction which results from an inhibition of the cranial division of the autonomic nervous system. If the stimulus is maintained for a short period, the inhibited action of the third nerve permits the sympathetic to gain control, and the pupil soon dilates. On the other hand if the patient is taken into a dark room where the pupil will dilate, and a strong stimulus of light is applied, the pupil will not contract; again showing the state of marked inhibition of the oculomotor mechanism. This point can be used in differential diagnosis of the benign and malignant schizophrenic reactions. A similar type of pupillary reaction is found in other affective states, such as the manic depressive and the psychoneurotic. In many the differential is not an easy task because the psychological phenomena are very much the same. Since this pupillar reaction is characteristic of types showing a similar onset, such as affective external projections of internal conflicts as we find in the organic schizophrenic reaction-type and the above mentioned states, it is reasonable to assume a disturbance in the diencephalon which produces similar reactions in the different psychological groups.

The most interesting clinical fact regarding this type of pupil is the more dilated and immobile the pupil, the more acute is the mental state. This same type of pupillary reaction is found in various organic infectious and toxic states. The neurological findings are the result of secondary toxic changes in the diencephalon, which are in no way different from those in other parts of the brain which produce the mental phenomena. As a matter of conjecture, the disturbed interofective mechanism, which is found in the organic schizophrenic reaction-type, may result from an unknown toxin, which produces neurological findings identical with some of our known organic toxic states. In many respects the clinical courses are similar, but the psychological expressions of the internal disturbances are quite varied.

Another important and ever-present finding is the rapid pulse rate. This characteristic is often taken as a symptom of thyroid disease and a part of the thyroid is removed. After the thryoidectomy the pulse rate remains rapid and the patients drift into the hands of psychiatrists from six months to three years later. It is the type

of tachycardia that does not amend to cardiac drugs. It does not respond to ordinary hydrotherapeutic measures, and is very unstable, in that the pulse fluctuates up and down under the same form of therapy. This group shows varying degrees of hypersensitiveness to heat and cold. The reactions from hot or cold baths vary. In those with the very rapid pulse (100-120), hydrotherapeutic measures, which increase the pulse usually aggravate the mental symptoms. Mental improvement follows a decrease in pulse rate. In contrast to this in the true schizophrenic with a normal pulse rate or even a bradycardia one can easily magnify the symptoms by hydrotherapeutics which slow the heart rate.

The mental phenomena are usually in the form of uncontrolled and disturbed affects, which lead to inadequate, senseless, bizarre and silly results. In the less severe affective states irritability may lead to hospitalization and soon a state of indifference coupled with oversensitiveness and contradiction of inner feelings, completes the clinical picture. Individuals of the "organic schizophrenic reaction-type" may have been considered sensitive, moody and hard to get along with; however, as stated previously, there is not enough evidence of psychopathology in their early life to alarm the members of their environment. The acute onset in this group is usually followed by a short clinical course and a social recovery. They may carry some residuals of their affective disturbance but the separation of associations from experience no longer exists and thinking is not dominated by complexes.

In the organic schizophrenic reaction-types, there is a border-line group, in whom there is a history of two or three attacks, or rather acute exaccerbations of their already unstable affective life. This group is very similar to the schizoaffective psychoses described by Kasanin two years ago. In this border-line group the onset is acute with a marked emotional reaction, which subsides in a few days to a few weeks. The group shows the same evidence of cranial autonomic inhibition as is found in the organic schizophrenic reaction-types. They also show a leucocytosis and an acceleration of the erythrocyte sedimentation, along with other evidence of a mild toxic state. The clinical course is very much the same as the group described by Kasanin. There is this difference, however; the group herein described was selected not from psychological data, but from evidence of cranial autonomic inhibition. It is surprising how well the clinical course and issue of the schizophrenias may be determined by this organic physiological syndrome. The constitutional schizophrenias described by Bowman and Kasanin do not show cranial autonomic inhibition. They are the malignant schizophrenias which develop early in childhood and which have more of the clinical findings of the normal or slightly vagotonic. They might well be termed the malignant schizophrenias with a grave prognosis.

In recapitulation, the syndrome of the "organic schizophrenic reaction-type" has the following characteristics: An inhibition of the pupillary constrictor mechanism; an inhibition of the cardio-inhibitory mechanism; an inhibition of the seventh nerve, with a hypo-ideo-kynesia to painful and pleasurable stimuli; an inhibition of affect with a type of thinking and behavior of the schizophrenic variety, superimposed upon a mild toxic state or occurring as a post-infectious sequela. These features are separate and distinct and are associated with an acute onset, a short clinical course, and recovery.

SUMMARY

An "organic schizophrenic reaction-type" is described which is a fairly classical entity found in the group of schizophrenias. The group as a whole shows certain symptoms which may be mistaken for sympathicotonic states and hyperthyroidism, but the neurological findings are characteristic of cranial autonomic inhibition. The onset is acute, the clinical course is stormy but short, the mental phenomena, thinking, feeling and acting are distinctly schizophrenic. The issue is a complete clinical and social recovery with no residuals of dementia.

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PATENT DUCTUS ARTERIOSUS.

Case Report of a Woman Sixty-five Years, Eleven and One-half Months of Age.

By J. G. BRODY, A.M., M.D., and ASHER RANDELL, A.B., M.D., YOUNGSTOWN, OHIO

THE presence of a patent ductus arteriosus is not a rare condition. However, so far as we know, there are only two cases in the literature in which the patient passed the age of sixty-five. Josefson[1] reported the oldest case of sixty-six years, but the correct diagnosis was not made until an autopsy was performed; the antemortem diagnosis being mitral stenosis. In 1928 White[2] reported the second case in a patient sixty-five years, nine months of age, in whom the correct antemortem diagnosis was made. The present case is that of a woman sixty-five years, eleven and one half months of age in whom the diagnosis was made twenty months before death.

REPORT OF CASE

Mrs. Mae E., born August 17, 1868, white female, came to the Cardiac Clinic of the St. Elizabeth's Hospital, Youngstown, Ohio, December 9, 1931, complaining of dyspnea of two years duration.

Family History—Father died at 56. Cause unknown. Mother died of carcinoma of the stomach at the age of 52. One sister, 50 years old, is living and well. No brothers.

Personal History—Patient had "palpitation" of the heart at the age of ten years, but it did not incapacitate her, and she was able to indulge in all childhood forms of play. There is no history of rheumatism. Menses began at age of 15. Menopause at 53. She was pregnant four times. The first child, now 31 years of age, is living and well. Following that there were two miscarriages and one still-birth.

History of Present Illness—Two years before coming to the hospital she began to notice shortness of breath which continued intermittently up to her admission. There was an occasional cough. Relief was obtained by taking some "green liquid" (probably Digitalis).

Physical Examination—A thin, olive complexioned, white female. Head and neck negative, except for some slight cyanosis of the lips. Thorax —Symmetrical, expands equally, respiration regular. Normal resonance, breath sounds normal but hurried, no rales. Heart—no precordial bulging. Apex beat in the fifth intercostal space, 1 cm. outside of the mid-clavicular line. On ausculation both heart sounds are heard distinctly at the apex, but at the base there is a continuous murmur heard best in the second left intercostal space about 2 cm. from the sternum with systolic accentuation. The murmur is also heard over the left scapular region. It has the characteristic "humming top" or "machinery" sound (also called "mill wheel" or "tunnel" murmur)[3]. Blood pressure—195 systolic, 95 diastolic. Pulse rate 125 per minute, respirations 32 per minute. No Corrigan pulse, no Duroziez sign, no capillary pulsation, or any other signs that may occur when the patent ductus is wide and there is much aortic regurgitation into the pulmonary artery. Abdominal aorta palpable and of good volume; no distention of the internal mammary, intercostal, scapular or deep epigastric arteries, thus excluding coarctation of the aorta which may be the cause of the patency in some cases. Abdomen—normal. Extremities—normal.

Laboratory Findings—Red blood cell count 3,410,000. Hemoglobin 70 per cent. White blood cell count 5,120. Polymorphonuclear neutrophiles 62 per cent. Lymphocytes 29 per cent. Large mononuclears 8 per cent. Eosinophiles 1 per cent. Wassermann and Kahn tests negative. Blood culture negative. Urinalysis—negative for sugar and albumen. Reaction acid. Specific Gravity 1.020. Microscopic—occasional leukocyte and hyalin casts.

X-ray Report—The Teleroentgenogram (Fig. 1) reveals a moderate general cardiac enlargement, more to the left than to the right, considerable calcification in the region of the aortic arch, and marked increase in prominence of the pulmonary conus (arc of Zinn).

Electrocardiographic Findings—The electrocardiogram (Fig. 2) shows a rate of 132 per minute, left axis deviation, and occasional auricular extrasystoles. The arteriogram (lower tracing in Lead III) shows no water hammer pulse, but a slight suggestion of a pulsus alternans.

The patient continued to come to the cardiac clinic for observation at regular intervals. Towards the end of June, 1933, she began to show increasing evidence of dyspnea and cyanosis, and



Fig. 1. Teleroentgenogram of Mrs. E.—Moderate general cardiac enlargement, more to the left than to the right. Considerable calcification in the region of the aortic arch, and marked increase in prominence of the pulmonary conus (arc of Zinn).

was admitted to the wards of the St. Elizabeth's Hospital on July 21. Her condition continued to grow worse and on August 1, 1933, she died of congestive heart failure.

POSTMORTEM EXAMINATION

A complete post-mortem examination* was generally negative except for such changes as confirmed the clinical findings and furnished the following summary:

Body was that of a poorly nourished elderly white woman, age 65 years 11½ months. Rigor mortis was present. The hair was gray. No alopecia or scars were found on the scalp. Head and face were symmetrical. Ears, eyes and nose appeared normal. No thyroid enlargement or asymmetry or bronchial clefts in the neck. Chest was symmetrical. Ribs were prominent with supra and infraclavicular depressions. Abdomen was scaphoid in shape; costal margins and iliac spines were prominent. No scars were present and very little subcutaneous fat was evident. Muscles of extremities were prominent and stiffened with rigor mortis. There was evidence of loss of flesh. The thoracic cavity showed no evidence of free fluid. The pleura was smooth and glistening. No adhesions to the lungs were found. The pericardial cavity was dry and slightly roughened. The lungs crepitated throughout and were normal except at the base which showed slight emphysema.

Heart appeared hypertrophied, and larger than normal. On section the left ventricular wall measured 7 to 28 mm. in thickness and the right from 5 to 8 mm. Both ventricles were hypertrophied. The papillary muscles of the left ventricle were thickened and sclerotic, and the chordae tendinae were shortened; those of the posterior mitral leaflet were calcified and adhered to the posterior ventricular wall. The anterior leaflet was matted with the chordae tendinae in a calcified mass which was adherent to the posterior wall of the left ventricle. On section through the aorta a large antemortem clot extending from the aortic cusps to the arch, with projections into the innominate, left common cartoid, and subclavian arteries was found. The aortic valve measured 7.5 cm. in circumference. The aortic cusps were slightly thickened; the left posterior cusp showed calcified deposits at its base. The pulmonary valve measured 7.5 cm. in circumference. The pulmonary cusps were normal. The pulmonary artery measured 8.5 cm. in circumference at its bifurcation. One and one-half centimetres above its bifurcation and opening off the left pulmonary artery was found a patent ductus arteriosus communicating to the aorta just below the arch (Fig. 3). The ductus arteriosus was 14 mm. long and measured 4 mm. in diameter at its pulmonic opening and 9 mm. in diameter at its aortic opening. Calcareous deposits were found at both ostia. The aorta was stiff, sclerosed, brittle and rough with calcareous deposits scattered throughout.

The abdominal cavity showed no evidence of free fluid. The intestines were mottled with a moderate amount of old plastic adhesions. The transverse colon was ptosed. The stomach was small with the distal half contracted to the size of a normal duodenum. There was a ptosis of the proximal two-thirds of the duodenum—only the distal third was retroperitoneal. The common bile duct, duct of Wirsung and duct of Santorini all opened separately into the free portion of the duodenum. The liver was slightly shrunken, and cut with the resistance due to a moderate amount of fibrosis. The gall bladder appeared normal and had no pericholecystic adhesions. The pancreas appeared normal in size and consistency. The jejunum and ilium were moderately plastic. No evidence of ulceration or perforation was found. The appendix was small, contracted and adherent to the posterior peritoneal wall. It measured 6 cm. in length and 4 mm. in diameter. The cecum appeared normal and there was a ptosis of the transverse colon.

The uterus was shrunken. The tubes were small and adherent to the posterior pelvic peritoneum. The ovaries were atrophic. The urinary bladder appeared normal. The left kidney appeared nor-

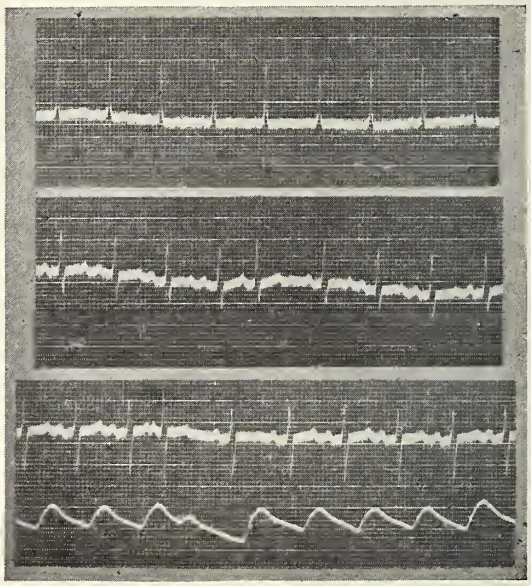


Fig. 2. Three leads of the electrocardiogram from a case of patent ductus arteriosus. Rate 132 per minute. Isoelectric P and T waves in Lead I. Left axis deviation. Occasional auricular premature contractions. There is a slight suggestion of pulsus alternans in arteriogram (lower tracing, Lead III).

1 cm. = 1 millivolt

*Autopsy was performed by Dr. S. R. Cafaro of St. Elizabeth's Hospital.

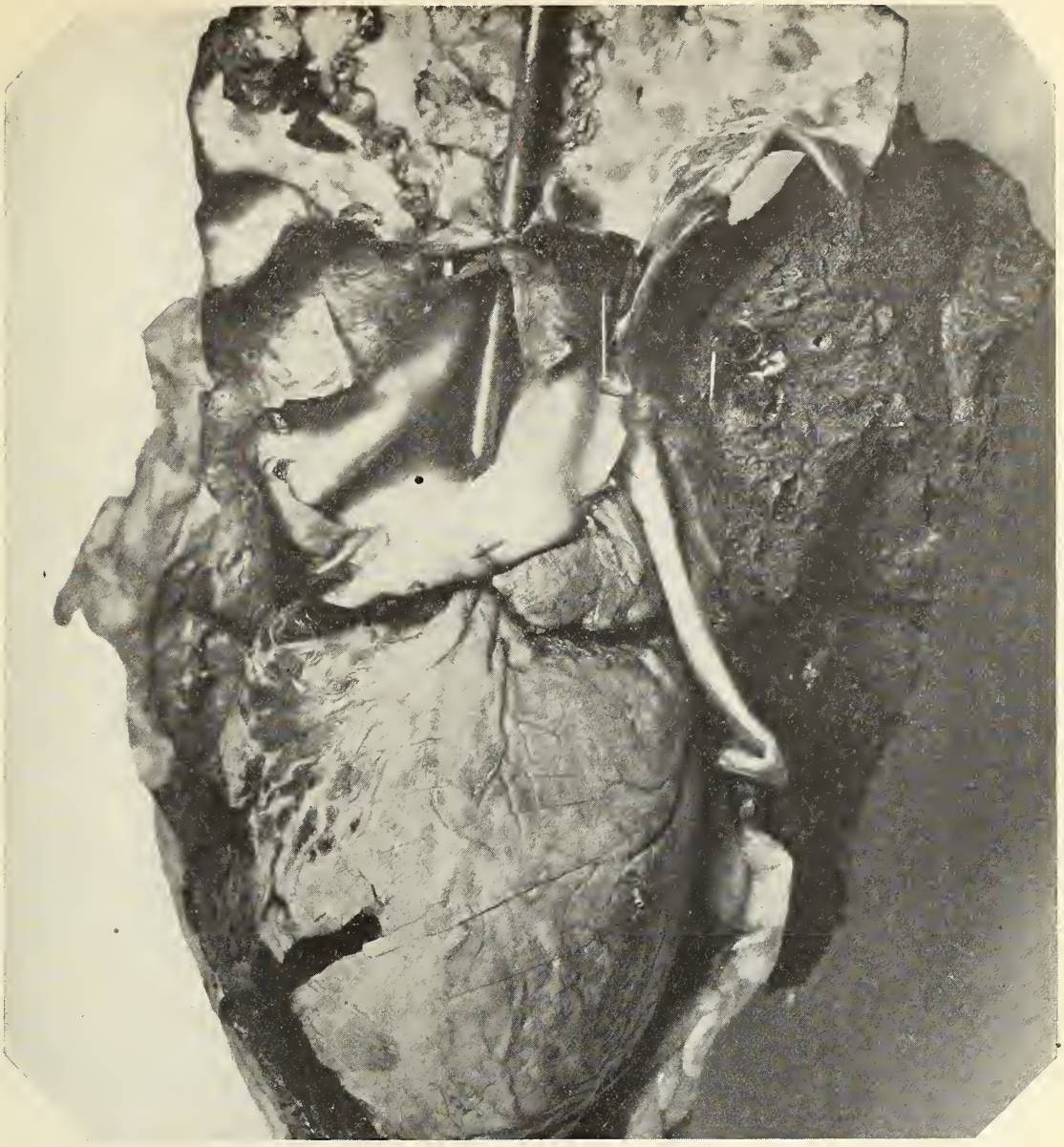


Fig. 3. Photograph of heart of Mrs. Mae E.—with patent ductus arteriosus. Instrument projecting through patent duct. Lower portion of instrument in pulmonary artery, upper portion in aorta. Note the extreme atheromatous condition of the aorta. Walls of pulumonary artery have been reflected in order to show interior. (Specimen preserved at the pathological museum of the St. Elizabeth's Hospital, Youngstown, Ohio).

mal in size. The capsule stripped with difficulty leaving elevated, white, miliary granules on its surface. On section it cut with a moderate amount of resistance showing ill-defined pyramids and a moderate amount of scar tissue deposit. The kidney pelvis appeared normal in size, but the calices were slightly dilated. The ureter appeared normal. The right kidney was absent. In its place was found a polycystic mass, and no ureter. The right renal artery and vein were not present. The spleen was normal in size and shape. Its cut surface appeared normal except for a slight increase in scar tissue.

SUMMARY

Patency of the ductus arteriosus uncomplicated by any other congenital cardiac defects, but associated with a congenital polycystic kidney and absence of the ureter and right renal artery and vein in a woman sixty-five years, eleven and one-half months of age recognized clinically twenty months before death. The oldest case of patent ductus arteriosus on record diagnosed antemortem.

The congenital polycystic kidney and other congenital abnormalities bear out the statements of

many investigators that congenital lesions rarely occur singly.

604-5 CENTRAL TOWER.

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—OSMJ—

New Books

National Medical Monographs, Edited by Morris Fishbein, M.D., and published by the National Medical Book Company, Inc., 119 West 41st St., New York City. Price, $4.00 per volume. The series of monographs, with titles and name of authors, are as follows:

Abnormal Arterial Tension, by Edward J. Stieglitz, M.S., M.D., F.A.C.P., Assistant Clinical Professor of Medicine, Rush Medical College, University of Chicago.

Obstetrics for the General Practitioner, by J. P. Greenhill, B.S., M.D., F.A.C.S., Professor of Gynecology, Loyola University School of Medicine, Chicago.

Industrial Medicine, by W. Irving Clark, A.B., M.D., Assistant Professor, Industrial Medicine, Harvard School of Public Health, Boston, and Philip Drinker, S.B., Ch.E., Associate Professor Industrial Hygiene, Harvard School of Public Health, Boston.

The Management of Colitis, by J. Arnold Bargen, M.D., F.A.C.P., Division of Medicine, the Mayo Clinic.

Commoner Diseases of the Skin, by S. William Becker, M.S., M.D., Associate Professor of Dermatology, School of Medicine, University of Chicago.

Diseases of the Chest, by J. Arthur Myers, M.D., Professor of Medicine, Preventive Medicine and Public Health, University of Minnesota Medical School.

Clinical Laboratory Methods and Diagnosis. A textbook on laboratory procedures with their interpretation. By R. B. H. Gradwohl, M.D., Director of the Gradwohl Laboratories; Director of the Gradwohl School of Laboratory Technique; Director of Laboratories, St. Louis County Hospital; Chief of Staff and Pathologist to Christian Hospital; Lieutenant Commander, Medical Corps, Fleet, United States Naval Reserve. With 328 illustrations in the text and 24 color plates. Price $8.50. The C. V. Mosby Company, St. Louis, Publishers.

The Autonomic Nervous System. Anatomy, Physiology and Surgical Treatment. By James C. White, M.D., Assistant Professor and Tutor in Surgery, Harvard Medical School; Assistant Visiting Surgeon, Massachusetts General Hospital, Boston. Price $7.00. The MacMillan Company, New York, Publishers.

Objective and Experimental Psychiatry. By D. Ewen Cameron, M.B., Ch.B., (Glas.) D.P.M. (Lond.) Physician in Charge, Reception Service, Provincial Mental Hospital, Brandon, Man.; formerly Assistant Physician, Glasgow Royal Mental Hospital; Assistant Resident Psychiatrist, Johns Hopkins Hospital, and Instructor in Psychiatry, Johns Hopkins University; Henderson Research Scholar, Volontairarzt, Stadtsanstalt; Burghoelzli, Zurich. Price $3.00. The MacMillan Company, New York, Publishers.

The Eponyms of Anatomy by Louis R. Effler, A.M., M.D., F.A.C.S., Toledo, Ohio. A series of brief essays on semi-popular medicine designed especially for the freshman medical student beginning anatomy, with a list of eponyms. Each of these essays is divided into two parts, first, a description of the itular structure, consisting of general definition, illustrations in other parts of the body, specific definition, anatomical description, physiological description and pathological description; second, a thumb-nail biographical sketch, consisting of date of birth, place of birth, education, contemporaries or co-workers, teachers, professorships with honors and awards, direction of research, discoveries, books or papers, miscellaneous (anecdotes, legends, etc.), character and influence on posterity. Press of McManus-Troup Co., Toledo, publishers.

—OSMJ—

Summary of Live Birth, Infant Mortality and Stillbirth Data

The Bureau of the Census has announced that in continental United States, during the calendar year 1934, there were 2,158,919 live births, 129,400 deaths of infants under one year of age, and 78,436 stillbirths. These figures represent a birth rate of 17.1 per 1,000 estimated population, an infant mortality rate of 59.9 per 1,000 live births, and a stillbirth rate of 3.6 per 100 live births. In 1933 the corresponding rates were 16.6, 58.1, and 3.7.

New York, Pennsylvania, Texas, and Illinois lead the states with the greatest number of births, as follows: 185,615; 160,238; 116,603; and 110,225, respectively. The states with the highest birth rates, however, were: New Mexico, 27.9; North Carolina and Utah, each 24.1; South Carolina, 24; Alabama, 23.4; West Virginia, 23.2; and Mississippi, 23. The lowest birth rates were 12.7 in California and 12.9 in New Jersey.

Infant mortality rates were excessively high in New Mexico (132.1), and Arizona (103)—both states with a large number of nomadic Mexicans and Indians who have little knowledge of infant care. The next highest rates were 86.1, 78.9, and 77.4 for South Carolina, Georgia, and North Carolina, respectively—all Southern states with large Negro populations. The lowest rates were those for Oregon and Washington, 39.8 and 43, respectively.

The ratio of stillbirths per 100 live births for the United States in 1934 was 3.6. Comparison of this ratio between the states should be made with caution, as there is no single definition of stillbirth in general use and the application of the term varies widely in the law and practices of the different states.

The number of live births in Ohio in 1934 was 99,906, with a birth rate of 14.6 as compared to 14.1 in 1933. Deaths under one year numbered 5,380, 53.9 per 1,000 live births compared to 52.7 in 1933. There were 3,277 stillbirths, 3.3 per 100 live births—the same as in 1933.

PUBLIC HEALTH--SOCIAL WELFARE--MEDICAL ECONOMICS *and* ORGANIZATION PROBLEMS

"Let There Be Light and the People Will Find Their Way"

In these days when the trend of government is to use every pretext to foist on the public and the medical profession more paternalistic forms of legislation affecting medical practice, it behooves the individual physician and organized medicine to take advantage of every proper means to acquaint the general public with the physician's viewpoint on medical-economic problems.

The Journal again and again has stressed the necessity of active participation by physicians in civic activities in which the public looks to the medical profession for counsel and leadership.

A laudable example of this is the recent action of the Cleveland Academy of Medicine in protesting against political interference in the administration of Cleveland City Hospital.

Complimentary and sound editorial comment in the *Springfield Sun* following an address by Dr. Charles L. Minor before the Springfield Rotary Club on "The Problem of Socialized Medicine" is typical of what can be accomplished by intelligent presentation of such subjects to civic groups.

Inasmuch as the *Sun's* editorial is evidence of the favorable effect which can be obtained through well-presented addresses given by well-informed members of the medical profession, we believe it merits reproduction in full. Captioned, "A Medical Problem", it read as follows:

"Dr. Charles L. Minor, in his address at the Rotary Club luncheon on Tuesday, explained how unsatisfactory state systems of medicine are. He agreed with the statement made many times that in this country the very rich, able to pay any necessary sum for medical services and the poor, who have such services provided for them, get the best medical attention, and that the group in between is the least well provided for. Physicians are giving this state of affairs a good deal of thought and hope to remedy conditions to some extent.

"There are ways in which this great middle class could do a good deal to remedy the conditions themselves. This class is supposed to be pretty well educated and supposed to be fairly intelligent. If on the average the members of this class behaved with the wisdom which their intelligence and education would lead one to suppose them to possess, conditions might be improved a good deal.

"The science of medicine has made rapid advances in the past few decades, but the majority of the members of the class in question remain under the domination of ancient ignorance. They believe what physicians may have once believed before present methods of obtaining exact information were possible, or they believe in old wives' fables, which never were accepted by physicians, or even greater absurdities, brand new, exploited as systems of health or as certain cures, without a shadow of scientific basis.

"Some disease is inescapable, at least in the present stage of the world, a good deal of it is avoidable. Ignorance concerning infection and neglect to take primary precautions against infection account for a great deal of disease which might be avoided. Reasonable care would prevent many accidents of all sorts, accidental poisoning from taking something out of the wrong bottle or eating improper food, accidents about the home, accidents in connection with fire and electricity and gas and carbon monoxide, accidents on the road and accidents of all classes. Intelligent people conducting their lives wisely can save themselves often from the need of a doctor.

"But an even greater folly of the class in question is neglecting to call a doctor at the proper time. Some people get themselves into a serious condition of ill health simply by neglect, and some by attempting to doctor themselves. Their doctor bills would be more within their ability to pay if they called the doctor in time instead of waiting until they began to feel desperate about their situation.

"There is a serious amount of penny wise, pound foolish conduct on the part of people who should know better. Many a small doctor bill in good season has saved the paying of a big one later on. The class so disadvantageously placed at present, could do much to help itself if only it behaved with more wisdom."

Other county societies and academies, through radio talks and speeches before civic organizations and luncheon clubs, are accomplishing much in acquainting the public with the physician's attitude on social problems. They are to be commended for the service which they are rendering the profession at a time when a complete understanding by laymen of the physician's viewpoint is extremely important. All societies should consider the possibilities of such contacts and plan to take advantage of such opportunities.

—OSMJ—

Watch The Schools, Indiana Editor Warns the Profession

An announcement recently released by The National University Extension Association states that it has arranged for 100,000 high school students in 40 states to debate the proposition: Resolved, That the several states should enact legislation providing for a system of complete medical

service available to all citizens at public expense".

It was somewhat of a coincident that the same day perusal was made of this interesting statement, our attention was called to an editorial published in the *Indiana State Medical Journal* which carried the caption, "Watch the Schools".

Needless to say the latter answers some of the questions raised by the statement of the university extension association. The points emphasized are so important and well-put, that they are worthy of reproduction.

"Schools teach children", the Indiana editor observes and adds:

"That is why we have schools. What do they teach the children? That is an important question because upon its answer hangs the fate of the nation and of its component parts. We are not finding fault with the schools. The writer of this article is a teacher, and believes in teaching as in nothing else. He thinks that in the main the schools are excellent, but just the same that they should be watched. Just now we are concerned with various practices and theories which seem to be disadvantageous to the medical profession and the best interests of medical science. Whether or not this tendency increases until it is a real menace will depend upon what the public, and in particular the young people, are being taught.

"School superintendents are aggressive, and are looking for ways of being helpful to the children. Surely they are not to be criticized for that. Unfortunately, however, they can not be expected to understand certain technical phases of the question. Let us suppose that they tell all of the children to come to the school physician for their immunizations, for treatment of their cuts and sprains, for treatment of colds and the like, for dental work and tonsillectomies, as they do already in some places. It seems very nice and apparently splendid for the children. It costs them nothing; the doctor is on a small salary and therefore it costs the school no great sum. The school doctor likes to be busy and to be of as much service as possible to the school and to the children. It is too much to suppose that the child or his parents will see the dangers in such an arrangement, but just the same the child is being taught to get something for nothing and is being weaned away from the relation which has caused the medical profession to be the most progressive and useful of all professions.

"In the recent immunization campaign there were only a few instances in which there was any serious difficulty or trouble. In nearly every one of these the reason was to be found in the fact that an ambitious superintendent of schools wishing to do the right thing, and being disgusted with the slow and apparently inefficient methods whereby consent of the parents was sought, decided to take the thing in his own hands, get all of the children together in a bunch, and have the school physician immunize them. There is no doubt that such methods would have immunized more children, but it would also have taught them to expect something for nothing, and thereby hangs the difficulty.

"What is being taught in the normal colleges concerning the relation of doctor and school? The medical profession has a right to know because it is one party to such an arrangement. If the normal schools are teaching that the schools are responsible for the medical care of the child, we should know about it. Maybe there are parents who will wish to retain that responsibility and maybe there are doctors who would like to have something to say about it. What is taught in the normal schools will probably be considered as law and gospel by the graduates who will be teaching thousands of children very shortly.

"What are the high schools and the liberal arts college teaching the fathers and mothers of the next generation concerning the relation of the family to the doctor? What are the professors in the medical schools teaching boys concerning these matters? Obviously the clinical professors may be expected to protect the rights of the profession, but it is possible that the full-time instructors may not understand the relation concerning which we are writing. There is no need to ask what is being taught by most of the social service groups and departments; we should have been asking that a number of years ago. It is so easy to solve certain social problems by sending the patient to the dispensary for free treatment, and it is so much easier to make a complete case record and have it all entirely under the control of the social service worker by handling it in that manner. But that is water under the bridge now. We should have had a finger in the teaching of the years gone by. "Too busy to monkey with it," we have said. Maybe we are still too busy to take part in the teaching of the public and the children of today, but if we know what is good for the profession we love, we will willingly find the time."

—OSMJ—

Youngstown Physician Offers Good Advice on Narcotic Question

Because of a determined effort on the part of Federal narcotic authorities to break up the illegal traffic in narcotic drugs and bring about strict enforcement of the Federal and state laws, physicians should be especially careful to comply with the statutes in every detail.

It will be remembered that articles on the narcotic statutes were published in the May and July, 1935, issues of *The Journal*, page 367 and page 539, respectively. These should be read by all physicians.

Also we believe physicians will be interested in some comments recently made by Dr. James L. Fisher, president of the Mahoning County Medical Society, in the *Bulletin* of that society.

His admonition to the profession read in part as follows:

"Many months ago Frank Lyons asked me to write something in the *Bulletin* about the proper way to obtain, prescribe, and dispense narcotic preparations. The subject did not appeal to me. Every doctor has a copy of the regulations sent him by the Internal Revenue Department, which he can read. But Professor Lyons said that many doctors did not seem to understand the importance of observing the regulations to the letter and that some of them might innocently get into serious trouble. Recently Ralph White told me the same thing and added that he sometimes receives prescriptions not properly made out which he could

not fill because the law makes the druggist jointly responsible.

"Events of the last month have borne out their predictions and, innocently or not, we find doctors in serious trouble. After sitting in Federal Court in Cleveland for two days listening to the trial of a case of violation of the Harrison Narcotic act, one is more than ever impressed with the importance of being extremely careful to live up to the letter as well as the intent of the law in the everyday practice of medicine. When you consider that your good name, your means of making a living, your savings and your liberty, may all be taken away because of a violation of this law, it assumes a place of major importance in the professional life of every doctor.

"Often I have heard some of my older colleagues say, 'All you need to do is practice honestly and do what is right and you will never be bothered about minor violations.' I wish this were true but unfortunately it is not, and I can cite instances where a doctor's sympathy and humanitarian instincts have led him into trouble. As to minor violations—in the recent trial in Cleveland the whole thing simmered down in the closing argument of the prosecution to a *technical* violation on which conviction was obtained. That *technical* violation was this: The Government claimed that the doctor had written a prescription for an amount of a narcotic for a patient and appriated it for his own use. The patient never got it. The prosecutor said this violated both purposes of the law—the collection of revenue and the protection of morals. The amount of revenue involved was one cent for an order form, but the moral issue was incalculable. How many of our doctors when they have needed morphine for their hypo cases have written a prescription for someone, instead of bothering with the official form, which is a nuisance to fill out and must be kept on file for two years? An old friend of mine, now dead, *always* wrote a prescription and he was the soul of honor. My druggist friends tell me that they believe it is done very frequently just to avoid the red tape. Think of the significant implications brought out when it is found that such prescriptions were not filled by the patient! Better to endure the red tape.

"Another way doctors are liable to get into trouble is by yielding to sympathy when faced with the sufferings of an addict deprived of his drug. These persons present such a miserable, abject and pitiful spectacle that no one could bear to see even an animal suffer so. The law states that narcotics can be administered to an addict who is aged and infirm to prevent death, but not in excessive amounts. The narcotic division believes that four grams a day is sufficient for each case. But all addicts are not aged and infirm. What can be done about saving their lives? Only one thing. The law permits administration of narcotic to a known addict only as part of the withdrawal treatment. This should be done in a properly equipped institution, under strict supervision, with careful records kept which show a reasonably rapid diminution in the dose. There is no other way you can treat a known addict without incurring the suspicion of catering to his addiction. The law is strict, you have no choice, and the penalty is severe.

"I do not believe that one doctor out of ten keeps proper records of narcotic preparations dispensed. The law here is ambiguous and space does not permit discussion of this phase. The study of this entire subject is just as important as the study of the medical side of practice and should not be neglected.

"In closing let me present a very important part of the subject not covered by the law, and that is the prevention of addiction. Every addict blames his plight on the administration of a narcotic by some doctor in the treatment of previous disease. I am not willing to believe that this is true even in a small proportion of cases, but nevertheless we should be extremely careful in the treatment of patients requiring the use of such preparations. Certainly the patient with painful, incurable disease which is bound to cause death should have all the morphine necessary to render him comfortable, but modern medical treatment as a general rule does not find it necessary to administer habit forming drugs over considerable periods of time to those with curable disease, especially if the symptoms tend to be recurrent. Modern pharmacology has so augmented our armamentarium that we have a wide choice of pain-relieving remedies. Let us be scrupulously careful not to produce an appetite for narcotics in any patient. Further than that let us be careful that no narcotic preparations through us shall fall into improper hands. The intent of the Harrison Act is laudable and by complying with it to the letter we are helping to stamp out a great evil."

—OSMJ—

The Medical Profession and The Press

A communication recently issued by the Committee on Public Health of the Massachusetts Medical Society on "The Hazards of Publicity", has caused considerable discussion in medical circles generally.

It deals with public advertising by members of the medical profession and types of publicity.

Of special interest are some of the comments on the brochure made by Dr. Iago Galdston, secretary of the Medical Information Bureau, New York Academy of Medicine, published in a recent issue of *The New England Journal of Medicine.*

Dr. Galdston admits that there are hazards in publicity. At the same time, he calls attention to the value of properly controlled and formulated publicity on medical and health questions.

His views are well summarized in the following paragraphs:

"The problem must be understood and dealt with in a pragmatic fashion. Certain it is that our economic and social world has changed much since the beginning of the century. There is an immense reading public with an avid curiosity about all things, medicine included. There is a highly organized industry, journalism, which serves this public curiosity and which thrives on opposition. We of the medical profession cannot cut ourselves loose from society to drift in our own little row boats. Even though we entertain

a sentimental reverence for the 'older accepted' ethics of medicine, which, by the way, are mainly wish fulfillment concepts, we must perforce face the current problems and meet them effectively. We meet them effectively when we cooperate with the press, when we aid the Fourth Estate in every legitimate fashion possible. True, some of the press's preoccupation with 'upside down stomachs', cornea transplants, etc., taxes our patience. But then, we must be philosophers. In time we are bound to gain, and so, too, will the public. Indeed, scrutiny of the press by a sympathetic eye will reveal that not infrequently the editorial page, feature articles, and not seldom the news columns, too, offer the reader sound advice, and excellent information on personal health and communal welfare.

"Yes, there are hazards in publicity, but there are also many gains for the courageous and the skilled who know, or are willing to learn how to utilize it for the greater glory of medicine and the greater good of our people."

As the medical profession well knows, those endeavoring to sell the public on untried schemes in providing medical care are past-masters in propaganda and publicity, and have commanded the interest of the reading public.

The reading public must be given both sides of these issues. Obviously, none but the medical profession can, or should, undertake to present the viewpoints of the medical profession. That it should be done is just as obvious. The responsibility rests upon organized medicine.

—OSMJ—

Tax Reformers Creating Dangerous Situation in Ohio

Two groups of tax reformers are now engaged in circulating initiative petitions among the electors of Ohio to force, through constitutional amendments, radical and far-reaching changes in the present system of levying and collecting state and local taxes.

Inasmuch as the deadline for filing these petitions with the Secretary of State is August 7, a concentrated drive is being waged, especially in the smaller cities of the state.

Physicians, as taxpayers and supporters of constructive legislation and good government, should be cognizant of the fallacies and dangers of these movements.

The Committee on Public Policy of the State Association has given this question much thought and following due deliberation issued, under date of July 18, a bulletin to all legislative committeemen summarizing pertinent facts and emphasizing certain bad features in connection with these undertakings.

The bulletin stated the situation so clearly that part of it is quoted herewith for the information of the entire membership:

"*This is dangerous business* and we believe every physician in Ohio should be warned of the *chaotic conditions likely to result* if they succeed in getting their proposals on the ballot at the November election.

"One proposed constitutional amendment, sponsored by the League for the Advancement of Social Justice, headed by Congressman Martin L. Sweeney, Cleveland, would, by changing the Ohio Constitution, forever prevent a consumer sales tax on food, clothing, building material used in home construction and coal used for domestic heating purposes.

"The other, sponsored by the Good Government League of Cuyahoga County, headed by Ex-State Senator Marvin Harrison, would restore the 15-mill real estate tax limitation and prevent the levying of all sales taxes.

"Doubtless, these petitions are being circulated in your county. For that reason we believe you and your colleagues should understand the seriousness of these movements and the dangers of this method of legislating.

"*First*—The Constitution should not be a legislative document. Enactment of laws, including taxation statutes, is a function of the State Legislature. It should not be hampered in working out an intelligent tax system by arbitrary limitations in the Constitution. We have witnessed on many occasions the fallacy of attempting to legislate through constitutional amendments.

"*Second*—If the foregoing proposals are placed on the ballot and adopted by the electorate, the taxation situation in Ohio will be no less than critical. Undoubtedly their adoption will force the enactment of a radical income tax law, a devastating tax on gross receipts from all business and professional pursuits, high-rate luxury taxes, a large increase in real estate taxes, or even various types of discriminatory professional and occupational taxes.

"*Third*—The State Legislature should be given an opportunity to work out an equitable and well-rounded taxation program without being hamstrung by questionable constitutional limitations.

"*Fourth*—Movements of this character encourage all radical and destructive groups, such as cultists and anti-medical organizations, to promote legislation by initiative petition. This does not allow an opportunity for judicious consideration of the merits of proposals. It permits selfish-interest groups to make misleading appeals to attract public sympathy and to capitalize on the gullibility of unthinking voters.

"It is suggested you discuss these points with your colleagues and that they in turn discuss them with their friends and acquaintances.

"Physicians can, of course, act as their judgment dictates. However, they should *proceed with the greatest caution* in signing these initiative petitions. Before signing, every physician should have a *full knowledge of the facts and the possible results.*"

It is suggested that readers of *The Journal* also study carefully a statistical article on the taxation problems of the state, published elsewhere in this issue.

N. Y. C. Surgeons to Meet in Columbus

The annual meeting of the Association of New York Central Lines Surgeons will be held at the Deshler-Wallick Hotel, Columbus, October 30-31, 1935. Included in the topics to be discussed are eye examinations, hypertension, medico-legal jurisprudence, mechanical drainage, diabetes, hand infections and injuries, symposium on fractures and early diagnosis of neuro-syphilis. Among the features of the meeting will be the surgical clinics and the annual dinner. It is expected that about five hundred surgeons and their wives will attend the convention. Dr. Sterling B. Taylor, Columbus, Chief Surgeon for the New York Central Railroad Company, and member of the Executive Committee of the association, is in charge of local arrangements.

—OSMJ—

Ohio Physicians Named Officers

At the eighty-sixth annual session of the American Medical Association held at Atlantic City, June 10-14, the following Ohioans were elected officers of sections: Dr. Joseph T. Wearn, Cleveland, secretary of the Section on Practice of Medicine; Dr. A. Graeme Mitchell, Cincinnati, alternate delegate, Section on Pediatrics; Dr. Russell L. Haden, Cleveland, secretary of the Section on Pharmacology and Therapeutics; Dr. John T. Murphy, Toledo, secretary of the Section on Radiology.

—OSMJ—

The American Board of Otolaryngology held an examination in New York City, June 8, and of the 109 candidates examined, 85 were certified and 24 were conditioned or failed. The board will hold an examination at Cincinnati, September 14, 1935, prior to the meeting of the American Academy of Ophthalmology and Otolaryngology. Prospective applicants for certificate should address the Secretary, Dr. W. P. Wherry, 1500 Medical Arts Building, Omaha, Nebraska, for application blanks.

—OSMJ—

A nation-wide campaign was launched June 12, by the National Health Council to stimulate interest in community health on the part of the citizens and taxpayers. At the close of the drive in October, open town meetings will be held throughout the United States to discuss public health. It was stated that the campaign is an attempt "to promote such special objectives in these communities as the local health and social agencies might think most desirable" and to coordinate all health and social agencies.

—OSMJ—

The 14th Annual Session of the American Congress of Physical Therapy will be held at the Hotel Kansas Citian, Kansas City, Mo., Sept. 5-12, 1935.

Have You Secured Hotel Reservations For the Annual Meeting?

MEMBERS of the State Association who have not already done so, should immediately send in their hotel reservations for the 89th Annual Meeting of the Association which will be held at Cincinnati, Wednesday, Thursday and Friday, October 2, 3 and 4.

With the A. M. A. meeting held at Atlantic City breaking all attendance records, and state conventions of other professional associations being exceptionally well-attended, an unusually large representation of physicians can be expected at this year's meeting of the Ohio State Medical Association.

It is important that requests for reservations *be made direct* to the management of the hotel selected, without further delay, so that the members will get the type of accommodations requested.

For the convenience of those who have not yet secured reservations, the list of Cincinnati hotels, their rates and accommodations, published in the June issue of *The Journal*, is again published.

NETHERLAND PLAZA

Headquarters Hotel

800 rooms, with bath; single room, $3.00 to $6.00; double room, $5.00 to $8.00.

HOTEL GIBSON

1000 rooms, with bath; single room, $2.50 to $4.00; double room, double bed $4.00 and $5.00; double room, with twin beds $5.00 and $6.00.

SINTON-ST. NICHOLAS

750 rooms, with bath; single rooms, $2.00 and up; double rooms, double bed $3.00 and up; double rooms, twin beds, $4.00 per day and up; suites, consisting of bedroom, parlor, reception hall and two baths, $6.00 per day and up single; $8.00 per day and up, double.

HOTEL METROPOLE

400 rooms, with bath; single rooms, $2.00 and $2.50; double rooms, $3.00, $3.50 and $4.00.

HOTEL ALMS

500 rooms with bath; single room, $3.00; double room, $5.00; two-room suite, $7.50.

FOUNTAIN SQUARE HOTEL

250 rooms with bath; single room, $2.00 to $3.00; double room, $3.00 to $4.50.

HOTEL HAVLIN

180 rooms; single room with bath, $2.00; double room with bath, $2.50; double room, with twin beds and bath, $3.00.

GUEST SPEAKERS AND SITE OF 89TH ANNUAL MEETING OF THE STATE ASSOCIATION IN CINCINNATI, OCTOBER 2, 3 AND 4



Upper left, Dr. Frank H. Lahey, Boston; *upper right,* Dr. James B. Herrick, Chicago; *lower left,* Dr. Palmer Findley, Omaha; *lower right,* Dr. Morris Fishbein, Chicago; *center,* The Netherland Plaza, Cincinnati, headquarters hotel. (See next page for "Who's Who" on speakers and time of their addresses).

BRILLIANT FIGURES IN MEDICAL WORLD TO APPEAR ON PROGRAM AT ANNUAL MEETING IN CINCINNATI

THE Program Committee for the 89th Annual Meeting of the Ohio State Medical Association, to be held at the Netherland Plaza Hotel, Cincinnati, Wednesday, Thursday and Friday, October 2, 3 and 4, has been especially fortunate in securing four out-of-state physicians of national prominence to address the general sessions.

Photographs of these guest speakers appear in the layout on the preceding page.

A short biographical sketch of each is presented herewith for the information of those who may be unfamiliar with their prominence in the field of medicine.

JAMES B. HERRICK

Dr. James B. Herrick, Chicago, Ill., will address the Second General Session, 3:00 P. M., Wednesday afternoon, on "Some Problems of Medical Diagnosis". Dr. Herrick graduated from Rush Medical College in 1888, received an honorary M.A. degree from the University of Michigan in 1907, and was again honored by the same University with an L L.D. in 1932. He was Professor of Medicine at Rush Medical College from 1900 to 1927, and is now Emeritus-Professor of that institution. A Fellow of the American Medical Association, he is also a member of the American College of Physicians, and an honorary member of the New York Academy of Medicine. Dr. Herrick is the author of "A Handbook on Medical Diagnosis", and has contributed to many medical journals on subjects of internal medicine.

FRANK H. LAHEY

Dr. Frank H. Lahey, Boston, Mass., will speak at the Third General Session, 3:45 P. M., Wednesday afternoon, on "Newer Advances in Hyperthyroidism and Hyperparathyroidism". Dr. Lahey received his M D. degree from Harvard Medical College in 1904, and was honored by Tufts College with the degree of Hon. Sc.D. in 1927. From 1913 to 1917 he was Professor of Surgery at Tufts Medical College. During the World War Dr. Lahey was a major in the Medical Corps of the United States Army, and was Director of Surgery of Evacuation Hospital No. 30, of the A.E.F., and in 1923-1924 was Professor of Clinical Surgery at Harvard Medical College. He is now Director of Surgery at the Lahey Clinic in Boston, Surgeon-in-Chief of the New England Baptist Hospital, and Surgeon to the New England Deaconess Hospital. Dr. Lahey is a Fellow of the American Medical Association and the American College of Surgeons, and a member of many other professional associations. He has contributed numerous articles on surgical subjects and is a speaker whose services are in great demand.

MORRIS FISHBEIN

Dr. Morris Fishbein, Chicago, Ill., will speak at the Fourth General Session, 8:15 Wednesday evening, following the annual addresses of the President and President-elect of the Ohio State Medical Association. Dr. Fishbein's activities in behalf of organized medicine are well-known to all members of the profession. He received his M.D. degree from Rush Medical College in 1912. At the time of graduation, he was awarded the Alumni Fellowship in Pathology, and became associated with Drs. Ludvig Hektoen and E. R. LeCount, publishing papers of a medical research character. In August, 1913, he became assistant to Dr. George H. Simmons, editor of *The Journal of the American Medical Association,* which position he held until 1924, when he was elected to succeed Dr. Simmons. In addition to being editor of *The Journal of the American Medical Association,* he is editor of *Hygeia;* associate clinical professor of medicine, University of Chicago; lecturer of history of medicine, University of Illinois, and a member of various councils and committees of the American Medical Association. Dr. Fishbein is a member of the American Public Health Association, Chicago Pathological Society, Institute of Medicine, American Association for the Advancement of Science, and a Fellow of the American Medical Association. He has made many significant contributions to medical and lay literature.

PALMER FINDLEY

Dr. Palmer Findley, Omaha, Nebr., will address the Ninth General Session at 11:00 A.M., Friday, October 4. His subject will be "Cancer of the Cervix". Dr. Findley received his M.D. cum laude degree at Northwestern University in 1893. During 1898-99, he studied in Berlin, Paris and Vienna, and from 1900 to 1908 was an instructor at Rush Medical College, and was Professor of Gynecology at the University of Nebraska from 1908 to 1920. He was a member of the White House Conference on Child Welfare and Protection as Chairman of the Section on Obstetric Teaching. He is the author of "Diseases of Women", "The Story of Childbirth" and other medical publications. A Fellow of the American Gynecological Society, Dr. Findley has been president of several professional associations, including the American Association of Obstetrics and Gynecology and the Nebraska State Medical Society.

MAKETEWAH COUNTRY CLUB, CHAMPIONSHIP COURSE OF THE CINCINNATI DISTRICT, TO BE SCENE OF 15TH ANNUAL TOURNAMENT OF MEDICAL GOLFERS, OCTOBER 1

DR. LOUIS FEID, Jr., Cincinnati, president of the Ohio State Medical Golfers' Association, with the assistance of his local committee, is making elaborate plans for the Fifteenth Annual Tournament to be held at The Maketewah Country Club, Cincinnati, on Tuesday, October 1, in connection with the 89th Annual Meeting of the Ohio State Medical Association to be held in that city, Wednesday, Thursday and Friday, October 2, 3 and 4.

During the past 20 years, three Medical Golfers' Tournaments have been held at The Maketewah Country Club, which is recognized as the championship course of the Cincinnati District. Its sporty lay-out, with rolling fairways, velvet greens, and strategically placed sand traps and hazards, will test the skill of the championship players and challenge the mettle of the average plain golfer. Both "lions" and "lambs" will have to pull out their best bag of tricks to total a score worthy of locker-room bragging. Most of the older members of the association will recall with pleasant memories the previous tournaments held at Maketewah.



Maketewah Country Club

COMMITTEE PERSONNEL

The Cincinnati Committee is under the General Chairmanship of Dr. Ralph Hatfield. Dr. Wesley L. Furste is tournament chairman; Dr. C. R. Deeds will head the sub-committee in charge of prizes and trophies; Dr. C. A. Price will be chairman of the Entertainment Committee; and Dr. W. H. Ventress and his assistants will handle the publicity in connection with the tournament.

Dr. Feid and his aides are determined to make this 15th Annual Tournament the best in the history of the Golfers' Association. In addition to the usual array of fixed events and their accompanying traditional trophies, there will be a large list of other attractive prizes and features. Arrangements have been made for visiting physicians to play the course prior to the tournament day and nothing will be left undone to make this year's event the "Outstanding Classic" of our medical golfers' organization activity. All that must be added to the good work of the industrious local committee is a record-breaking attendance of physicians from all over the state. Be sure to make early plans to be present for this golfers' play-day.

ANY MALE MEMBER ELIGIBLE

Dr. J. J. Marek, Cleveland, who won the Association Championship last year at the Columbus Country Club with a score of 157 for the 36 holes of medal play, will be present and prepared to defend his coveted crown against all challengers.

An announcement concerning the tournament will be mailed in the near future to all members of the Golfers' Association. Every male member of the Ohio State Medical Association is eligible for affiliation and to participate in the tournament upon the payment of a $2.00 enrollment fee which covers life membership. Those wishing to join the association as new members may either mail their check for $2.00 in advance to Dr. J. B. Morgan, Secretary - Treasurer, Medical Arts Building, Cleveland, or pay the fee at the first tee on the day of the tournament.

Officers of the Golfers' Association for 1935 are: President, Dr. Louis Feid, Jr., Cincinnati; First Vice-President, Dr. M. R. Haley, Dayton; Second Vice-President, Dr. E. R. Marker, Toledo; Third Vice-President, Dr. F. W. Watson, Columbus; Fourth Vice-President, Dr. J. J. Marek, Cleveland; Fifth Vice-President, Dr. O. P. Tatman, Chillicothe; and Secretary-Treasurer, Dr. J. B. Morgan, Cleveland.

NEW CRISIS IN MEDICAL RELIEF SITUATION LOOMS AS THE FERA STARTS NEW WORKS PROGRAM AND LAYS PLANS TO TURN BACK DIRECT RELIEF TO LOCAL SUBDIVISIONS

NEW problems in connection with medical care of the poor, calling for ingenuity and aggressive action on the part of organized medicine, can be anticipated during ensuing months.

This prediction is based on two recent developments:

1. Inauguration of the nation-wide Works Progress Program of the Federal Government through which it is hoped to provide jobs for 3,500,000 persons now on the relief rolls.

2. Announcement by the Federal Emergency Relief Administration at Washington that budgets for direct relief, particularly that portion financed by Federal funds, must be drastically curtailed, in some instances 50 per cent, on or about August 1.

The new work relief program has started in Ohio. Although few, if any, actual projects have been begun, the administrative set-up has been organized and arrangements made for starting projects as rapidly as possible.

STATE TO HAVE 16 DISTRICTS

The state will be divided into 16 WPA (Works Progress Administration) districts. Millions of dollars in Federal funds will be allocated to Ohio for various kinds of projects. Relief officials hope eventually to put somewhere in the neighborhood of 250,000 persons to work on them before Winter. Wages ranging from approximately $50 to $100 a month will be paid. The Federal Government will administer this big program through the present FERA office at Columbus in charge of C. C. Stillman, who also retains the position of FERA administrator for Ohio. Those eligible for WPA jobs must have registered with the regular Federal Re-Employment Agencies and 90 per cent of those selected must have been receiving direct relief. As soon as persons are given employment on WPA jobs their names will be taken from the relief rolls and they will be expected to provide a living for themselves and their families from their WPA wages.

The fact that relief activities in Ohio are being handled directly by the FERA and an efficient office has already been established in this state, will enable the WPA to get its program underway in Ohio sooner than in most states.

At the same time, it means the direct relief rolls in Ohio will decrease more rapidly than in many states and that a greater number of persons will be confronted with the responsibility of providing necessities for themselves sooner in this state than elsewhere.

RELIEF ROLLS SHOW DECREASE

A gradual decline in the relief rolls in Ohio has been taking place during the past six months. The figure for July was approximately 850,000 persons, compared to about 1,267,000 last January. The figure for August is expected to show a still greater decline, because of drastic cuts in direct relief budgets and the start of some of the new work projects. It is hoped to have 60,000 relief clients at work by mid-August.

What will happen in Ohio so far as medical relief is concerned is a matter of conjecture.

MUST PROVIDE OWN NECESSITIES

As long as the Federal Government continues to furnish money for direct relief, some funds will be available in Ohio for medical care of those on the relief rolls. The amount will depend on the number of persons retained on direct relief. Those employed on Works Progress projects will be expected to provide medical attention for themselves and their families out of their monthly wages. There is a possibility that a ruling may be secured from the Federal officials which will permit local relief directors to provide WPA employes with supplemental relief in the form of food, clothing, fuel, medical care, etc., in instances where their wages are insufficient to provide them with a subsistence budget.

Mr. Stillman has asked local relief directors to cut their budgets for August approximately 50 per cent. This would indicate he expects a substantial reduction in the number of persons on the relief rolls. Also, it would indicate that the Federal Government has definitely decided to withdraw from direct relief at an early date.

When and if the Federal Government relinquishes the job of providing direct relief, including medical care, this responsibility must be assumed by the state and local political subdivisions. Many now on the relief rolls are unemployable for one reason or another and will have to be provided with necessities indefinitely.

WILL BE LOCAL RESPONSIBILITY

There is at present no state agency with the proper facilities for administering direct relief. The old State Relief Commission passed out of the picture last Spring. Direct relief has been administered by the FERA office at Columbus. When the Federal Government gives up direct relief work, this office will be absorbed by the WPA.

Administration of direct relief will, therefore, become a responsibilityy of the local political subdivisions. Of course, the state can, if it desires, establish a centralized relief agency but it is doubtful if this will be done. The state undoubtedly will have to contribute something for poor relief and distribute it among the local communities.

The Carey bill enacted at the recent regular session of the General Assembly authorizes local subdivisions to issue poor relief bonds and makes the county commissioners the administrative body. The commissioners can delegate this authority to the FERA as long as it continues to function in Ohio or to the proper officials of cities and townships within the county.

It may be assumed that, in all probability, direct relief in the not distant future will be handled on a county basis by the county commissioners or some authority named by them to handle it.

MEDICAL SOCIETIES MUST BE ALERT

Obviously, each county medical society and academy of medicine must be prepared to meet this situation. Contacts should be made immediately with local government officials. A plan of providing medical care for the poor should be developed in each county through conferences between representatives of the county medical society and government officials. Conditions and needs in individual counties will differ, so each county should adopt a medical program best suited to its own requirements.

If this is done at once, when and if direct relief work is returned to the counties and cities the basis for an efficient medical relief program will have been formed and can be put into operation without delay.

Until the FERA gives up direct relief, the present medical plan set up under Rules and Regulations No. 7 will continue in effect.

REVISED MEDICAL PLAN IN OPERATION

Most physicians doubtless are familiar with the improvements made in the plan as a result of negotiations between the FERA officials at Columbus and the Policy Committee of the State Medical Association.

In an article in the July, 1935, issue of *The Journal*, page 534, changes in the medical set-up were reviewed. These became effective July 1 and have been incorporated in the Revised Manual on Medical Care, issued by the FERA office at Columbus on that date. It is suggested that every physician participating in the medical relief program secure from his local relief director a copy of the Manual so that he can familiarize himself with the rules and regulations.

One provision in the Revised Manual calls for the formation of a medical advisory committee in each county. It is hoped that all county medical societies have taken advantage of this opportunity and have contacted their local relief directors on this matter.

ADVISORY COMMITTEE PROVISION CLARIFIED

Following the issuance of the Manual, some question arose as to the functions of the advisory committee. To clarify the matter, the following bulletin was sent to all county relief directors by Dr. John B. C. Eckstorm, medical advisor of the FERA in Ohio, which is self-explanatory:

"You will note in paragraph 'g' under 11 Procedure of the revised Medical Manual dated July 1, 1935, that each county in cooperation with the appropriate medical society will set up an 'advisory committee'. As there has been some question as to the function of the 'advisory committee' we submit the following for your information.

"The function of the Advisory Committee is to advise the local relief administration on the medical, dental, and nursing problems, and assist in administering the medical program in their community. Such Advisory Committee shall cooperate at all times with the local relief administration in keeping the local medical relief program functioning so as to provide adequate medical care for all on relief rolls, in auditing monthly bills for professional services, medicine and medical supplies, in seeing that those rendering such services and furnishing such supplies are promptly and adequately compensated, and in recommending disciplinary action against those guilty of questionable practices in connection with the rendition of professional services or sale of medicine and medical supplies.

"If the physician on the Advisory Committee chooses to give a designated number of hours up to 3 or 4 a day for field service which shall include checking up on doubtful cases, contacting other physicians, etc., for the good of the service, he may do so. This does not mean that a clinic is to be established by him or professional services rendered by him as a member of the Advisory Committee. The physician acts in an advisory capacity only. These activities, however, do not prohibit such physician from participating in the medical relief program if he so desires."

There also has been some misunderstanding about Paragraph F of Section 1 (Policy) of the revised Medical Manual, which reads as follows:

"Where the subdivisions have regularly employed physicians on a salary or fee basis, Federal funds may not be used to replace this service. Any physician receiving a stipulated salary from a subdivision for medical care for indigents may not receive payment from FERA funds for treatment of relief clients."

INTERPRETATION IS REQUESTED

Following the receipt of communications from physicians in several counties, stating their local relief directors had interpreted this to mean that physicians paid a salary by a subdivision regard-

less of the character of their services are prohibited from receiving FERA medical fees, the Policy Committee of the State Association took up the matter with the FERA office and requested a clarification of the provision.

It was pointed out by the Policy Committee that, obviously, a physician employed by a township, county or city on a salary to render medical care to the poor *should not* be permitted to receive FERA fees, but that a physician employed on a salary for medical or health activities which *do not include the rendition of medical care* (curative) to the poor *should* be permitted to participate in the medical relief program of the FERA and be paid in accordance with the FERA fee schedule.

Physicians interested in this provision should confer with their local relief director and emphasize to him that Paragraph F precludes only physicians paid a stipulated amount by the local subdivision for *care of the poor.*

An important phase of the new Works Progress Program which has not been decided as yet is that which has to do with providing medical care for those disabled in the course of or as a result of their employment.

MEDICAL CARE FOR INJURED WPA WORKERS

It is understood unofficially that a plan similar to that used under the CWA will be inaugurated. That is, compensation and medical care for injured WPA employes will be administered by the United States Employes' Compensation Commission. Injured employes doubtless will be given comparatively free choice of physician and hospital. A clearing house for WPA injury claims will be maintained at the WPA headquarters office but all claims will be passed upon and paid by the U. S. Employes' Compensation Commission, Washington. No information relative to medical fees is now available but it has been indicated that no standardized national medical fee schedule will be established.

These impending changes in the relief picture indicate that difficulties and complications will confront medical organization during the ensuing months. Physicians who have been receiving authorizations for the care of indigents from local FERA directors may anticipate a big drop in the number of such authorizations. Local subdivisions will be expected for a time to share with the FERA the responsibility of providing relief for those unable to secure WPA employment and eventually take over all direct relief work. Therefore, it is highly important that every county medical society get busy at once and devise a local medical plan mutually agreeable to physicians and the officials of local subdivisions ready to operate when the FERA withdraws from direct relief.

P.W.A. Funds For Health Projects

L. A. Boulay, P. W. A. engineer for Ohio, has announced that the inventory of possible public works projects for Ohio includes several county tuberculosis hospitals totaling $1,250,000, as follows: Ashtabula, $125,000; Butler, $250,000; Columbiana, $175,000; Jefferson, $175,000; Miami, $125,000; Muskingum, $100,000; Wood, $125,000.

Projects either built or under construction comprise the Cincinnati General Hospital, remodeling contagious ward, $30,000; Hamilton County Tuberculosis Hospital, occupational therapy building, $140,512; Huron Road Hospital, East Cleveland, $336,000.

In addition, the State Department of Public Welfare soon will start projects at the Cleveland State Hospital, Cincinnati Longview Hospital, Dayton State Hospital, Delaware Girls' Industrial School and Apple Creek institutions totaling $1,205,000, on which the federal government gave a grant of $34,325, Boulay disclosed.

—OSMJ—

Health Survey in 50 Cities Planned as Federal Work-Relief Project

A national health inventory covering 50 representative cities to determine the extent and severity of arthritis, Bright's disease, infantile paralysis, and other physically incapacitating maladies may be undertaken as a Federal work relief project.

The U. S. Public Health Service has requested an allotment of $3,450,000 of work relief funds to finance such a project, claiming that at present little information is available as to the geographical differences in the occurrence of these chronic diseases and the variations with respect to age, sex and occupation.

A survey of medical facilities for the treatment of chronic diseases is included in the project. Data would be assembled on the extent of illnesses lasting three months or more.

In making this request, the Public Health Service explains that diseases of the type which would be studied are more prevalent among older persons, and therefore information concerning them is of increasing importance in view of the growing percentage of the population past 60 years of age.

As a final phase of the survey, it is proposed that the regular research staff of the United States Public Health Service carry on an intensive study of the data to determine the effect of these diseases upon employability.

—OSMJ—

The 64th Annual Meeting of the American Public Health Association will be held at Milwaukee, Wisconsin, October 7-10.

LICENSES TO PRACTICE MEDICINE IN OHIO ISSUED TO 295 AT MID-SUMMER MEETING OF STATE MEDICAL BOARD

TWO hundred and ninety-five licenses to practice medicine and surgery in Ohio were granted by the State Medical Board, at its regular mid-summer meeting held in Columbus on July 9.

Certificates to practice their respective limited branches were granted to 9 osteopaths, 5 cosmetic-therapists, 34 chiropodists and 2 masseurs.

At the business session of the Board, the certificate of Dr. L. P. Jackson, Columbus, to practice in Ohio, was revoked on a charge of conviction of a felony.

The certificate of Dr. W. B. Glenn, Cleveland, was suspended for violation of the narcotic law, and he was given the opportunity to appear before the Board in six months to show cause why he should be reinstated.

Louise Schroeder, R.N., was re-appointed to the nurse examining committee for a period of three years.

The highest grade in the June examinations was made by D. J. Mullholand, McCutchenville, graduate of Ohio State University, College of Medicine, with an average of 89.1 per cent. R. C. Bane, Detroit, Mich., also a graduate of Ohio State University, College of Medicine, was second with 88.6 per cent. Third place was taken by A. L. Moore, Cincinnati, graduate of the Eclectic Medical College, Cincinnati, with a grade of 87 per cent.

Those granted medical and surgical licenses on examination, with their school of graduation and place of residence, follow:

Ohio State University College of Medicine, Columbus—Edwin H. Artman, Piqua; Benedict B. Backley, Cleveland; Charles S. Baldwin, Mt. Vernon; Olen D. Ball, Caldwell; Russell C. Bane, Columbus; Henry Batsch, Akron; Floyd C. Beelman, Columbus; Thornton I. Boileau, Madeira; Emery J. Braun, Cleveland; Elizabeth A. Bremner, Elyria; David Brown, Columbus; Frank A. Catalano, Cleveland; Joseph Chervinko, Columbus; Arthur R. Cohen, Cleveland; William C. Craig, Columbus; Ewing H. Crawfis, Ottawa; Forder F. DeMuth, Hicksville; Lloyd L. Dowell, Carrollton; Samuel C. Ellis, Xenia; Samuel Epstein, Youngstown; Melvin F. Eyerman, Columbus; Darrell B. Faust, Mansfield; Donald J. Feerer, Columbus; Karl H. Feistkorn, Columbus; Edgar E. Findlay, Columbus; Warren R. Flanagan, Kenton; Sam Friedmar, Toledo; Eugene M. Fusco, Niles; John A. Gabel, Columbus; Theodore V. Gerlinger, Fostoria; Theodore Golden, Columbus; Marcel Greenberg, Cleveland; Arthur A. Greenlee, Columbus; Robert C. Grubbs, Columbus; Henry L. Hilty, Columbus; Zeph J. R. Hollenbeck, Columbus; Joseph E. Horton, Caldwell; James J. Hughes, Fremont; Herman H. Ipp, Youngstown; William M. Jennings, Jr., St. Mary's; Karl F. Kaufman, Cleveland; Henri A. Kerns, North Lewisburg; Charles K. Kincaid, Troy; Jack E. Klinge, Massillon;

David R. Lewis, Lilly Chapel; Hugh K. Long, Dennison; Domenic A. Macedonia, Columbus; Nathan W. Manow, Cleveland; Archie J. Martin, Dillonvale; Richard L. McFarland, Piqua; Harlan P. McGregor, Cincinnati; Robert E. Merrill, Toledo; Paul D. Meyer, Cleveland; William F. Mitchell, Columbus; Daryl J. Mullholand, McCutchenville; James W. Norris, Columbus; Deane H. Northrup, McConnelsville; Alva J. Payne, Wilgus; Raymond G. Plummer, Columbus; Lillian M. Posch, Cleveland; William K. Romoser, Columbus; John R. Scherer, Portsmouth; Albert L. Schonberg, Cleveland; Leon M. Shulman, Columbus; Robert F. Slotterbeck, Bloomdale; Herman C. Smith, Cleveland; Stanley C. Sneeringer, Mansfield; Frank L. Snyder, Hamilton; Frederick E. Spangler, Somerset; Donald R. Sperry, Newark; Maurice E. Stilwill, Massillon; Thomas L. Taylor, Monclova; James E. Thompson, Columbus; James R. Thompson, Akron; John M. Thompson, Jr., Columbus; Arthur J. Tronstein, Cleveland; Ray M. Turner, Springfield; Harold Unger, Cleveland; John P. Urban, Columbus; John F. Ury, Columbus; Samuel L. Weir, Carrollton; Arthur E. Wentz, South Charleston; Rex H. Wilson, Akron.

University of Cincinnati College of Medicine, Cincinnati—Alexander S. Angel, Cleveland; Allan A. Baldwin, Lorain; Arthur I. Blieden, Cincinnati; Raymond M. Carmichael, Cincinnati; Charles A. Castle, Cincinnati; Marcus E. Cox, Greenfield; Rank O. Dawson, Cincinnati; Edward J. Devins, Cincinnati; Charles A. DeWert, Wyoming; Harry Dworkin, Cincinnati; Benjamin Felson, Cincinnati; Gerald A. Foster, Warsaw; Julius Gelperin, Cincinnati; Fred Goldman, Cincinnati; Sander Goodman, Cincinnati; Jacob E. Hershberger, Cincinnati; Philip J. Holabach, Cincinnati; Robert G. Hunter, Cincinnati; Eugene L. Huwe, Cincinnati; Felix L. Ittleman, Cincinnati; Charles Jarvis, Jr., Cincinnati; Carroll C. Johnson, Cincinnati; Stewart R. Jones, Cincinnati; Joseph R. Kahn, Cincinnati; Isaac Kawasaki, Cincinnati; John J. Kearney, Cincinati; Meyer Kurzner, Cincinnati; Charles C. Lemert, Cincinnati; Simon J. Mason, Toledo; John R. McBride, Cincinnati; Edward W. McCall, Columbus; William L. McGowan, Cincinnati; Cecil D. McIntire, Cincinnati; John R. Meek, Cincinnati; Edward B. Mersch, Cincinnati; James F. Mills, Cincinnati; William P. Montanus, Springfield; David A. Nathan, Cincinnati; Virgil A. Plessinger, Cincinnati; Laurence M. Quill, Cincinnati;

John E. Reed, Cincinnati; Samuel Reingold, Cincinnati; Joseph E. Ricketts, Cincinnati; Samuel S. Rockwern, Cincinnati; Herschel Sachs, Cincinnati; Bernard Safer, Cincinnati; Leon S. Saler, Cincinnati; Richard J. Sanderson, Delta; Gilbert E. Sayle, Shaker Heights; John H. Siehl, Cincinnati; Mathias F. Strashun, Cincinnati; Ralph W. Tapper, Dayton; Paul Troup, Dayton; Frank W. Vockell, Cincinnati; George H. Wadsworth, Cincinnati; Carl F. Wagner, Cincinnati; Herbert Warm, Cincinnati; Andrew J. Weiss, Cincinnati; Marcus W. Westervelt, Cincinnati; Armine T. Wilson, Cincinnati; Phillip J. Woodworth, Athens; George W. Yauger, Cincinnati.

Western Reserve University School of Medicine, Cleveland—Forest D. Adams, Elyria; Rudolph F. Antoncic, Cleveland; James J. Badal, Cleveland; Frederic D. Baier, Cleveland; William B. Baily, Cleveland; Myron J. Barker, Niles; Samuel Beckerman, Cleveland; Alton W. Behm, Cleveland; Marion H. Bertling, Cleveland; Henry L. Bookwalter, Columbiana; Harold J. Bowman, Canton; John A. Clark, Cleveland; Louis F. Cleary, Caldwell; Irving I. Cramer, Cleveland; Harry E. Crimm, Cleveland; William E. DeVol, Cleveland; Lincoln C. Dickey, Cleveland; Edward A. Dunlap, Cleveland; Charles H. Engelfried, Jr., Cleveland; Sidney Feuer, Cleveland; William E. Forsythe, Jr., Cleveland; Robert P. Fulton, Cleveland; William R. Funderburg, Cleveland; Ferdinand V. Geiss, Cleveland; Paul M. Glenn, Cleveland; Vernon L. Goodwin, Youngstown;

Joseph L. Greene, Cleveland; William H. Gronemeyer, Cleveland; Mark G. Herbst, Canton; Henry L. Hoffman, Cleveland; Howard H. Ingling, Springfield; Edgar S. Ingraham, Jr., Cleveland; John B. Johnson, Jr., Cleveland; Sidney Katz, Cleveland; Donald A. Kelly, Cleveland; George R. Krause, Cleveland Heights; Franklin M. Krichbaum, Canton; Andrew J. Lamb, Jr., East Cleveland; Edwin A. Lawrence, Cleveland; Edward L. MacDougall, Youngstown; Angel M. Marchand, Cleveland; Irvine H. Marshall, Cleveland; James E. Miller, Toledo; Oliver F. Miller, Jr., Cleveland; Earl F. Nation, Cleveland; James M. Norris, Woodsfield; Mary R. Oldt, Cleveland; Orien B. Patch, Cleveland; Kenton R. Phelps, Cleveland; Gerald W. Quinn, Akron; Paul E. Reading, Cleveland; Theodore S. Rosen, Cleveland; Warren C. Sawyer, Marion; Roger F. Scherb, East Cleveland; William B. Seymour, Jr., Cleveland; Harold C. Shafer, Cleveland; George R. Smith, East Canton; Jasper A. Smith, Cleveland; Ralph A. Smith, Tiffin; Ralph B. Sommerfield, Cleveland; Aubrey L. Sparks, Columbus; Joseph M. Strong, Cleveland; Virgil E. Terrell, Cleveland; Norman VanWezel, South Euclid; Arthur L. Watkins, Cleveland.

Eclectic Medical College, Cincinnati—Thomas F. Betts, Findlay; Julius E. Chalfin, Cincinnati; Ruth C. Ferris, Cincinnati; Charles Froug, Dayton; Gilbert E. Garvin, Cincinnati; Charles P. Harris, Cincinnati; Herman J. Hepp, Norwood; Ralph A. Heringhaus, Cincinnati; Roy A. Justice, Cincinnati; Morris Malmud, Cleveland; Herbert Mandelstein, Cincinnati; Alfred L. Moore, Cincinnati; Lester Stepner, Cincinnati; Sol Taplits, Cincinnati; Ralph F. Wilkins, Cincinnati; Samuel Zatuchne, Cincinnati.

Other Schools—Frederick W. Rea, New Philadelphia, Cornell University; J. Frederick Doyle, South Vienna, Creighton University; Henry A. Brown, Chillicothe, Harvard Medical School; Walter Beckh, Cleveland, Johns Hopkins University; Clare C. Kenny, Cleveland, Loyola University; Delmas E. Greeneltch, Columbus, University of Louisville; Michael A. Tarro, Ravena, Loyola University; Wilfrid M. Gill, Cleveland, Marquette University; Otis E. Marler, Cleveland, Northwestern University; Raymond K. Bartholomew, Dayton, Rush Medical College; Frederick H. Dobbs, Milford, Rush Medical College; Chester R. Jablonoski, Cleveland, St. Louis University; John H. Mowry, Conneaut, St. Louis University; Joseph Mackiewicz, Toledo, University of Buffalo; Louis E. Barron, Columbus, University of Chicago; James K. Herald, Youngstown, University of Maryland; Agnes M. Hoeger, Cincinnati, University of Minnesota; Edward J. Simon, Shaker Heights, Washington University; Evelyn A. Adams, Cincinnati, Woman's Medical College of Pennsylvania; James O. Mattox, Toledo, University of Western Ontario; Ilse Seidemann, Cleveland, University of Breslau; T. M. Hayes, Dayton; R. S. Koehler, Dayton; D. J. O'Leary, Toledo; C. F. Ward, Cleveland; and E. A. Weizer, Cleveland, all graduates of Loyola University, Chicago.

Licensed Through Reciprocity — Harold J. Abrams, Cleveland, University of Louisville; Richard M. Anderson, Haydenville, Washington University; John A. Bender, Cleveland, Harvard University; Otis O. Benson, S. Solon, Keokuk Medical College; Lloyd A. Busch, Dover, University of Pittsburgh; Rundle D. Campbell, Youngstown, Rush Medical College; Harold N. Cavanaugh, Reading, St. Louis University; Lewis W. Cellio, Youngstown, St. Louis University; Thomas S. Charvat, Cleveland, St. Louis University; Harve M. Clodfelter, Columbus, University of Kansas; John D. Czarnecki, Toledo, St. Louis University; David C. Frick, Toledo, St. Louis University; Norton H. Gilbert, Cleveland, St. Louis University; Henry C. Harris, Cincinnati, Tulane University; Leonard H. Harris, Elyria, Northwestern University; Roger C. Henderson, Clifton, University of Chicago; William W. Herman, Cleveland, Washington University; Frank R. Hill, Cleveland, University and Bellevue Hospital Medical College; John F. Hillabrand, Perrysburg, University of Michigan; Meritt S. Huber, Cleveland, University of Louisville; Charles L. Hudson, Cleveland, University of Michigan; William R. Hutchinson, Orient, Medical College of Virginia; Clifford F. Jones, Cleveland, State University of Iowa; Vermont D. Kerns, Columbus, University of Louisville; Paul R. Lecklitner, Canton, Jefferson Medical College; David H. Levy, Youngstown, Indiana University; Robert R. McDonald, Cincinnati, University of Pittsburgh; Robert J. McCaffrey, Cleveland, St. Louis University; Auren W. McConkey, Canton, University of Tennessee; Jack Meltzer, Cleveland, St. Louis University; Paul J. Niederkorn, Versailles, St. Louis University; Timothy F. O'Connor, Ashtabula, St. Louis University; Alice M. Posey, Cincinnati, Rush Medical College; Turner Pursley, McConnelsville, Vanderbilt University; Donald J. Rehbock, Cleveland, University of Pennsylvania; Edwin A. Riemenschneider, Cleveland, Johns Hopkins University; Paul H. Schmiedicke, Napoleon, University of Wisconsin; Richard V. Schneider, Toledo, St. Louis University; John F. Smith, Montpelier, University of Illinois; Stewart J. Smith, Bowling Green, University of Michigan; Harold D. Waltz, Cleveland, Northwestern University; Morris Weinblatt, Toledo, University of Michigan and Homer A. Wilson, New Lexington, University of Pittsburgh.

— OSMJ —

—Paul H. King, Detroit, president of the International Society for Crippled Children, was the principal speaker at the annual meeting of the Elyria Memorial Hospital.

— OSMJ —

—Work of constructing an $80,000 cottage for male tubercular patients at the Dayton State Hospital will be started within the near future.

CRITICAL TAXATION PROBLEMS TO CONFRONT LEGISLATURE IN THE FALL; PHYSICIANS SHOULD BE PREPARED TO EXPRESS THEIR PERSONAL VIEWS ON PROPOSALS

As pointed out in *The Journal* on several recent occasions, the proposed special session of the Ohio Legislature to be held this Fall promises to be one of the most important legislative gatherings in the history of the state.

It will be called primarily to enact tax laws. However, the call may be extended to consider proposed changes in the Workmen's Compensation Law and various types of social insurance. There is a possibility that one or more bills to provide for some system of compulsory state health insurance will be introduced.

Public interest is focused at this time on proposed taxation measures. A joint legislative committee created to study various taxation measures and to recommend legislation is meeting frequently in Columbus and accumulating a large amount of data on a wide variety of proposals of this character.

The medical profession of Ohio should be vitally interested in this question. Physicians are substantial contributors to the operation of local and state governments. They should be prepared to voice their personal views on taxation questions to the legislators from their communities.

The seriousness of the taxation problem which will confront the Legislature—incidentally the public at large—when it convenes this Fall is emphasized in the following statement recently issued by the Ohio Inter-Organization Tax Association, through its president, C. A. Dyer, Columbus:

"A serious tax problem will confront the Ohio Legislature at its coming special session to provide new taxes. It is estimated that public schools will require $48,000,000; old age pensions, $14,000,000; poor relief, $15,000,000; relief bonds, $4,000,000; municipal and county governments, $20,000,000.

"To meet these requirements, estimated receipts will be—sales tax, $50,000,000; liquid fuel tax, $10,000,000; intangible taxes, $5,500,000; surplus in General Revenue Fund (created by the Governor's veto of $8,790,693.31 of items in the general appropriation bill), $7,500,000. The cigarette tax is not included in the above, as it is already encumbered for 1936.

"So, a probable deficit of $28,000,000 must be taken care of by the legislature; this means the levying of taxes which can be collected quickly and surely."

VARIOUS PROPOSALS SUMMARIZED

In a bulletin disseminated recently by Don K. Martin, executive director of the Ohio Manufacturers' Association, formerly executive secretary of the State Medical Association, there appeared a list of proposals for additional taxes now under consideration and a rough estimate of the possible yields of each.

Believing physicians of Ohio are interested in this important question and should be informed on taxation developments, *The Journal* presents herewith Mr. Martin's tabulation:

GROSS RECEIPTS—Two per cent (gross on incomes and sales to take the place of the sales tax) estimated to provide per year	$60,000,000
INCOME—Gross tax of 1%, approximately	27,000,000
Earned income tax, with rates graduated from one to 7 per cent and Federal exemptions	5,000,000
Individual income tax, or earned and unearned incomes, with Federal exemptions and graduated rates from 1 to 7 per cent and surtax on unearned	7,000,000
Individual income tax (Ward bill)	20,000,000
This bill, introduced during the regular session, is expected to be one of the major issues in the coming special session. It is considered by many students of taxation to be practically confiscatory in the higher brackets of income ranging to a maximum of 70% tax—the rates being higher than any other state income tax law.	
SELECTIVE GROSS INCOME—One per cent gross of	
Electric companies	$ 1,160,000
Natural gas companies	406,000
Telephone companies	477,000
Steam railroads	295,000
PAY ROLL—Tax of 1%	15,000,000
INTANGIBLE—Increase on bank deposits and shares to 3 mills	2,500,000
Productive investments from 6 to 7½%	2,070,000
Doubling all intangible tax rates	14,000,000
TANGIBLE—On 100% of value of personal property	8,000,000
CHAIN STORE—Modeled after Indiana law	600,000
Modeled after West Virginia law	1,200,000
SEVERANCE—Coal at 15 cents per ton	3,750,000
Coal at 5 cents per ton	1,250,000
SELECTIVE SALES TAX AT TEN PER CENT—	
Electric refrigerators	150,000
Chewing gum	30,000
Amusement instead of present 3%	3,100,000
Cosmetics	950,000
Jewelry	300,000
Other luxuries	5,000,000
Safety Deposit Box rentals	50,000
Newspaper Advertising	2,600,000
Radio Advertising	900,000
Out-door Advertising	200,000
Street car advertising	100,000
Radios, musical instruments, published music and other luxuries	2,500,000
Confectionery, ice cream, soft drinks, fountain-mixed, carbonated beverages	4,500,000
Sporting goods, games, cameras, badges	1,000,000
Bus fares	200,000
OTHER SELECTIVE SALES TAXES—Two and one-fourth cents a pound on tires and four cents a pound on inner tubes	400,000
Two cents a gallon on lubricating oils	200,000
One cent increase in gasoline tax in addition to present 4 cents	9,500,000
Fifty cents per telephone	350,000
Matches at rate of one-half cent per thousand in book form and 2 cents in wooden boxes	50,000
EXCISE TAX ON "SERVICE"—On the same schedule as the present sales tax to cover "all contracts or agreements for service whether professional or non-professional or for work or labor performed or effort put forth"	6,000,000
MISCELLANEOUS—Transfer on stocks and bonds	100,000
One cent bank check tax	150,000
License and privilege tax of $10 on tourist camps	$ 50,000
Tax on conveyances, deeds and instruments, 50 cents on valuation of $100 to $500, and each additional fraction at 50 cents	$ 50,000

WARNING ABOUT SIGNING PETITIONS

The Ohio Manufacturers' Association bulletin

also commented on petitions being sponsored by several groups for constitutional amendments on taxation and voices the opinion "if any or all of these proposals are adopted, the taxation situation in Ohio will be chaotic and almost irremediable".

The three sets of petitions now being circulated would provide as follows, the Ohio Manufacturers' bulletin stated :

A. To prohibit the levying of a tax on the manufacture, sale or consumption of food, clothing, building materials, and coal used for domestic heating purposes. This proposal is sponsored by a committee headed by Congressman Sweeney of Cleveland.

B. Gross earned income with the following special provisions:
   1. To prohibit the taxation of real estate and personal property and substitute therefor a gross income tax.
   2. To fix a 5 mill limitation on gross earned incomes up to $100 per month, but to allow additional levies to be voted on such incomes.
   3. To permit the legislature to fix tax rates on gross incomes in excess of $1,200 per year.
   4. To license all motor vehicles at $1.00, such license fee to be valid for the life of the vehicle.
   5. To impose a chain store tax of $2.00 for the first store, $4.00 for the second, doubling the tax for each additional store.

C. 1. To prohibit sales taxes on the necessities of life.
   2. To limit the gas tax to 3c per gallon, such tax to be used only for highway purposes.
   3. To raise the taxes on real and personal property to 15 mills, allowing additional taxes to be voted by a majority of the electors.
   4. To provide a minimum license fee of $5.00 on pleasure motor vehicles, such license fee to be in lieu of all other taxes.
   5. To provide a uniform rule for real estate taxation, and exempt family dwellings from taxation up to $5,000 in value for each building or double.

The bulletin quoted from a warning of the Ohio Inter-Organization Tax Association to the effect that "the electorate of Ohio will do well *not* to sign initiative petitions".

BUDGETS SHOULD BE BALANCED

Of special interest in this connection is the statement issued by the Ohio Institute, an independent organization engaged in the study of governmental problems under the heading "Back to Balanced Budgets".

The statement read in part as follows:

"Ohio has reached a crucial point in the financing of local government. . . . Not only have $44,000,000 of poor relief bonds been authorized, but over $20,000,000 of deficiency bonds and scrip have been issued and more than $55,000,000 of refunding bonds approved to retire maturing indebtedness. . . .

"Several factors have contributed to the sharp reduction of local revenues in recent years, the chief being tax delinquency, the shrinkage in property values, and the adoption of the ten mill tax limit. . . .

"Counties and municipalities are unquestionably confronted with a financial crisis. No doubt further economies are still possible in many cases, but against these must be balanced increased prices and the growing necessity for the restoration of salary scales. Economy alone cannot possibly solve the problem. Either there must be a drastic curtailment of what we have come to consider essential services, or money must be found with which to finance the services. . . .

"It is vital that this problem be promptly faced. Local budgets are now being framed, and if extra levies will be required, the necessary local legislation must be adopted by early September. The time has come for Ohio local governments to balance their budgets and return to a pay-as-you-go basis so far as current operation is concerned. We cannot afford an orgy of deficiency borrowing with its many evils. If additional taxes must be voted to maintain essential functions, we must either provide them or make up our minds to curtail the services. The issue must eventually be faced and it is vital that it be faced now and with courage and foresight."

Physicians would do well to study carefully the foregoing data. As citizens and taxpayers they have a perfect right to express their opinions to members of the Legislature on questions of taxation, as well as other proposed legislation, and especially on measures which would be discriminatory and place unfair burdens on those engaged in professional pursuits.

—OSMJ—

Throng Attends 100th Birthday Party Given for Bethel Physician

Many physicians from Southwestern Ohio, members of the Odd Fellows Lodge from all parts of the state, and countless neighbors and friends thronged to the little town of Bethel, Saturday, July 6, to do honor to Dr. William Eberle Thompson, said to be the oldest practicing physician in the United States, who celebrated his 100th birthday anniversary on that date.

The ceremonies honoring Dr. Thompson included the unveiling of an oil painting of him in the Municipal Memorial Building; an address by Dr. John A. Caldwell, Cincinnati, president of the Ohio State Medical Association, and special ceremonies by the Independent Order of Odd Fellows, of which Dr. Thompson is the oldest living member in the nation.

Many of the 1800 persons at whose birth Dr. Thompson officiated during 75 years of continuous practice in Bethel attended his birthday celebration. They included a woman born 69 years ago, and a little girl born last November.

The last of 12 physicians in his family, Dr. Thompson says he has no intention of retiring at present.

PROVISIONS OF MATERNAL AND INFANT WELFARE AND PUBLIC HEALTH SECTIONS OF SOCIAL SECURITY ACT SUMMARIZED; POLICIES AND PRINCIPLES FOR ACTIVITIES DRAFTED

AT the time this was written, the Federal Social Security Act was in conference committee subsequent to passage by both houses of Congress.

Its final enactment may be anticipated as soon as the houses can agree on minor differences.

The act contains two sections which refer to public health. One has to do with maternal and infant welfare and the care of crippled children. The other has to do with the general development of state and local public health work.

During recent weeks, several conferences have been held in Washington. These were attended by representatives of the U. S. Public Health Service, the U. S. Children's Bureau, public health officials from the various states and representatives of organized medicine.

At these conferences certain definite policies were adopted and principles agreed upon to serve as a guide for carrying out the programs provided for in the two sections.

Members of the medical profession must be familiar with the legislation on which these programs will be based, the proposed activities under the programs, and the fundamental principles of organized medicine with respect to such activities.

A. M. A. SUMMARY OF ACT

Doubtless many readers of *The Journal* have already read the brief but comprehensive summary of the public health sections of the Social Security Act, published in the June 29, 1935, issue of *The Journal of the American Medical Association*, page 2351.

In order that those who have not had an opportunity to study that comment may do so, *The Journal* presents part of it as follows:

"Two sections of the Economic Security Bill are specifically devoted to public health: title V, which deals with maternity and child welfare and the care of crippled children and which is to be administered by the U. S. Children's Bureau, and title VI, which has to do with public health programs in state and local communities and which is to be administered by the U. S. Public Health Service. Both sections provide for federal subsidies to states and territories in varying amounts and under varying conditions.

"Title VI of the Economic Security Act provides ten million dollars for preventive medicine to be administered by the U. S. Public Health Service. Of this, two million dollars is to be used by the service itself for research purposes and eight million dollars for aid to states. It is contemplated that this eight million dollars shall be used for aid to the state and territorial health departments in providing adequate facilities especially for the promotion and administrative guidance of full time city, county and district health services, to strengthen the service divisions of state and territorial health departments and to aid city, county and district health departments. The administrative plan advanced by the U. S. Public Health Service, as amended and accepted by the Conference of State and Provincial Health Authorities, provides six basic requirements for a state or territorial health department: namely, a qualified full time health officer; adequate provision for administrative guidance of local health services; acceptable vital statistics service; acceptable state public health laboratory service; special services for study, promotion and guidance of local activities for preventable disease control; and study, promotion and supervision of environmental sanitary control. Similar provisions are made with relation to city, county and district health departments.

"The financial allotments are under five major divisions. First is a flat grant, under which $400,000 will be allocated among the fifty-one divisions (that is, forty-eight states, the District of Columbia, Alaska and Hawaii), amounting to $7,843 for each jurisdiction. This money is an outright grant, not to be matched by state funds. The sum of four million dollars is to be allotted to the states on a per capita basis and must be matched by state funds in two ways; that is, two million dollars on a per capita basis to be matched dollar for dollar from existing appropriations for state health work and another two million dollars allocated on a per capita basis but to be matched dollar for dollar with new appropriations, except that where a state has already customarily appropriated liberally for public health work the requirement of new appropriations may be waived and the state may receive its allotment by matching dollar for dollar with existing funds. The sum of $1,200,000 is to be allotted for the purpose of equalizing the burden of public health work in accordance with economic conditions and needs of the states and territories, this having been determined by expressing by states the total income of the population on a per capita basis and determining the need of the individual state by its deviation from the median per capita income of the fifty-one state and territorial jurisdictions. Another $1,200,000 is to be allotted to the states and territories on the basis of such geographically limited health problems as hookworm, malaria and plague; this is to be matched by state and local funds. An additional $1,200,000 is set aside for purposes of training and provision of reserve personnel. Payments to states from allotments will be made dollar for dollar only to the extent that these funds are actually called for by plans submitted and approved.

"To summarize: The outright gift to the fifty-one health jurisdictions and the equalization fund based on financial requirements need not be matched by state and local funds; other allotments must be matched, but exceptions may be made in the matching requirement with respect to the population-basis allocation of funds. The training fund will be administered by the U. S. Public Health Service; allotments will be made to the several states but need not be matched.

"At the conference called by the U. S. Chil-

dren's Bureau a plan was presented for carrying into effect title V of the Economic Security Act, which has to do with maternal and child health and care of crippled children and makes available $3,800,000 for each fiscal year beginning with 1936. This is divided into a matched fund giving $20,000 to each state, the District of Columbia, Alaska and Hawaii, and dividing among these jurisdictions in proportion to the number of live births the sum of $1,800,000; as much of these two apportionments as may be used are to be matched dollar for dollar with state funds. There is also provided in this title of the act a free fund of $980,000 to be allotted according to the financial need of the individual state as determined by the Secretary of Labor, taking into consideration the number of live births. Conditions required to be included in state plans for maternity and child welfare which shall be approved by the Chief of the Children's Bureau include financial participation by the state, administration or supervision by the state health department, such reports as the Secretary of Labor may require, extension and improvement of local maternal and child health services, cooperation with medical, nursing and welfare organizations, and development of administrative services in needy areas.

"Services for crippled children are to be carried out through the Children's Bureau by means of a matched fund of $20,000 to each state, the District of Columbia, Alaska and Hawaii, and no free fund. This program differs from the rest of the programs under the act in that it is not a program of public health and disease prevention but is frankly a program for the medical care of crippled children. It may not always be administered by the state health department as the other activities under the act will be. It contains the same general requirements as outlined for the maternity and child welfare functions, including cooperation with medical, health, nursing and welfare organizations. This is the part of the program that is most directly liable to be in competition with the private practice of curative medicine. This portion of the program is being studied by the Bureau of Medical Economics with respect to its possible relationship to the Bureau's special report adopted by the House of Delegates at Atlantic City.

"In the plans that the Children's Bureau has drawn up for administration of the maternal and child health provisions of the act are plans for cooperation with state medical societies and with nursing, welfare and other agencies and organizations through advisory committees and cooperative and educational activities. A similar cooperative relationship with county medical societies is proposed in carrying out the local programs.

"The act provides for advisory committees to the Surgeon General of the United States Public Health Service and the Chief of the United States Children's Bureau. The intention has been declared to request official representatives from the American Medical Association to serve on these committees. The State and Provincial Health Authorities of North America adopted a resolution requesting publication in medical and dental journals of a statement outlining the general purposes of public health plans under the act and assuring the medical profession that they do not contemplate competition in the private practice of curative medicine.

"The conference with the Public Health Service and that with the Children's Bureau were marked by a frequently expressed desire and determination to cooperate with the medical profession in the making and carrying out of plans. It is therefore important that each state medical society shall be prepared to cooperate with the state health officer, the responsible administrative head in each state or territorial jurisdiction, in the development of plans that accord with the principles of organized medicine. Such cooperation might be through the council of the state medical society or such other body as might be designated for the purpose. Full information, including copies of the reports as amended and adopted, will be distributed to secretaries of state medical societies as soon as they can be prepared by the Bureau of Health and Public Instruction."

DEVELOPMENTS MUST BE CAREFULLY FOLLOWED

Ohio physicians who recall the difficulties which followed the inauguration of programs under the old Sheppard-Towner Maternity and Infancy Act will realize the importance of an active interest on the part of organized medicine in the contemplated programs and constant contact with officials formulating and administering such programs.

It is anticipated that officials in charge of the two programs will seek the advice and cooperation of medical organization. This point was particularly emphasized at the Washington conferences.

Some idea of the policies likely to be followed and the scope of the activities to be carried on is found in a report of the Committee on Child Hygiene to the Conference of State and Provincial Health Authorities of North America in which plans for developing the maternal and child health program were proposed.

The report said in part:

EDUCATIONAL AND DEMONSTRATION SERVICES

"The general program should be one of consultation, education, and demonstration services with aid to states and territories, and through them to local communities, and would involve State and local administrative leadership by public health authorities in close cooperation with medical groups. Such a program would also require cooperation in planning and in procedure with Federal and State authorities that are administering other phases of the public health program with those departments of Federal and State Governments that have to do with the administration in the fields of social welfare, education, and labor, and with other National and State professional and lay organizations. In addition to the general program for maternal and child health, special programs are suggested for demonstration and research in the development of more adequate provisions for maternal care and in other aspects of the child health program in rural areas, and for the care of crippled children, especially those in areas that are predominantly rural.

"In the furtherance of the general program of maternal and child health, special consideration should be given to local services for children and mothers, services to be administred by local public

health units, and with the use of combined local, State and Federal funds, to conditions in rural and other specially needy areas, to the development of demonstration services or services of a more nearly permanent character in localities in special need, and to the development of adequate divisions of maternal and child health in state departments of health that can provide the leadership and administrative assistance necessary to develop local services.

COOPERATION IS STRESSED

"In planning for a local health program for mothers and children in counties or districts, especially in rural areas and small centers of population, it is believed that emphasis should be placed on the development by the health authorities in cooperation with medical and other local groups, of certain minimum health services for mothers and children unable to obtain them otherwise and on state and local programs for education of lay and professional groups in the essentials of adequate maternal and child care. The use of local committees on child health and welfare (composed of representatives of local professional and lay groups) to assist in developing the educational program, in establishing the minimum services and in extending them to meet local needs should be considered in developing any plan. In the light of experiences in the recent past in many sections of the country and of the urgent need, it is believed that medical and dental services should be provided preferably by local physicians and dentists qualified to do the special work required, and paid by the local health department. Nursing service should be provided through the employment of full-time public health nurses by local health departments to work under the general direction of the health officer and under the immediate supervision of public health nurses experienced in such supervisory work. When local physicians and dentists are not available, other arrangements for the various services would have to be made. The educational and preventive aspects of both maternal and child health services should form an important part of the service rendered by physicians and dentists. In all of the health services, full cooperation of local medical and dental groups should be obtained.

MUST REFER THEM FOR TREATMENT

"Though it is not the function of physicians conducting a health service to render general medical care to the sick, it should be their responsibility as part of a preventive program and in cooperation with local medical, nursing, welfare, and social service groups to see that provision for adequate care is made through private physicians and dentists or, in the case of children in families unable to provide the necessary care, through appropriate welfare agencies. In the maternal and child health field this is especially necessary for the correction of remediable defects that handicap the normal growth and development of children and for the provision of adequate obstetric care of women at and following delivery. Plans for cooperation with hospitals, convalescent homes and other institutions for care of the sick or handicapped should be worked out with physicians, medical social workers, and others.

A continuing program of education in the essentials of adequate maternal and child care should be developed by local or community health services in cooperation with medical groups, education authorities, nutrition experts, and others. Though such a program of education is probably carried out most effectively in the form of an individual instruction by physicians and nurses as already outlined, it should also include health instruction in schools, group instruction of adults, community organization for the establishment or improvement of health services for mothers and children, the use and distribution of printed matter such as bulletins and posters on child and maternal health emphasizing preventive measures, health habits, nutrition and general standards of good care. Education in the field of mental health may be developed through any of these channels as qualified personnel are available for this aspect of the total health program.

PRIMARILY ADVISORY IN NATURE

"In order to develop local health services for mothers and children, leadership should come from the State Health Department through its division of maternal and child health and, for those local communities unable to develop even minimum services, assistance also in the form of funds or personnel or both. The function of a division of maternal and child health is primarily advisory and educational in nature, the program developing along the lines of (a) consultation with and guidance of local communities in developing their services for mothers and children, (b) demonstration of services in local communities for which personnel may need to be provided, (c) assistance in the provision of permanent services in localities in special need, (d) state-wide educational programs for both lay and professional groups in maternal and child care. In its activities, the division would necessarily work in cooperation with other divisions of the state health department; the state departments of welfare, education, labor; and with those medical groups that are specially concerned with the health of children and mothers, and with the general medical groups of the State and local communities."

—OSMJ—

Pan-American Medical Meeting at Marion Attracts Many

Several hundred Ohio physicians attended the meeting at Marion, June 19, sponsored by the local chapter of the Pan American Medical Association. The speakers and the subjects discussed follow: Dr. Fred H. Albee, New York, professor of orthopedics, New York University, "Fracture of the Hip", illustrated with colored moving pictures and slides; Dr. Dean Lewis, chief surgeon, Johns Hopkins Hospital, Baltimore, Md., "Traumatic Surgery", with colored moving pictures and slides; Dr. Russell L. Cecil, professor of medicine, Cornell University, "Fever Therapy"; Dr. L. M. Rosenthal, assistant to Dr. Max Cutler, director of the tumor clinic, Michael Reese Hospital, Chicago, "Indications and Contra-Indications of Radiation in the Treatment of Cancer"; Dr. Claire L. Straith, Detroit, Mich., "Plastic Surgery and the Traffic Problem, Especially the Treatment of Crushing Facial Injuries"; and Dr. Robert A. Lyon, assistant professor of pediatrics, University of Cincinnati, College of Medicine, "Nutrition".

THE DOCTOR'S COMPANY

Timely and Pertinent Advice On How the Physician In Private Practice Can and Should Keep Up With the Parade Given by Dr. Blankenhorn In Commencement Address at Western Reserve University.

MUCH has been written and said relative to the importance of post-graduate medical education. It *is* important. The physician who fails to keep up with his colleagues in their pursuit of new information and knowledge fails in his obligation to his patients and himself.

For some reason, however, many who have spoken or written on the subject have made it appear as if continuation of medical education is an ardous undertaking—something that requires the expenditure of large amounts of time, energy and money; travel to foreign lands; concentration on momentous problems almost to the breaking point. Can this be so? We believe not.

There are many opportunities whereby every physician can improve himself and at the same time not neglect his practice, sacrifice too greatly or wear himself out physically.

This point was delightfully emphasized recently by Dr. M. A. Blankenhorn retiring professor of clinical medicine, School of Medicine, Western Reserve University, in his adress to the recent graduating class at the school. Some readers may not agree with all that Dr. Blankenhorn said in his presentation "The Doctor's Company". Regardless of personal viewpoints, Dr. Blankenhorn's advice to those about to enter active practice must be recognized as thought-provoking and timely. For these reasons, his remarks are herewith published in full and may the chips fall where they will:

* * * *

YOUR departure from classroom and laboratory has determined the occasion of giving you a considerable volume of advice. My departure from this university has singled me out as one to offer you advice. There is no necessary assumption that you are in need of advice or that I am qualified to give it—we mutually accept the fact that custom victimizes us together.

The advice I feel inspired to proffer is suitable to the doctor who has been a few years in practice. Since it is highly improbable that any of you will seek advice when you are experienced, I must give it while I have the chance. What concerns me pertains to medical societies—the company the doctor keeps—and their importance in continuation of medical education; i.e., keeping up. (As I have seen doctors in more than 20 years of practice, I can classify them as to their state of keeping up into three main types; first, those who read books; second, those who read journals; and third, those who go to medical meetings.) This classification ignores the doctor who does none of these things—which is all right and quite proper. He deserves to be ignored.

The book man is the rarest type, and the one who is the most up in his subject—this is because the man who reads books also reads journals and usually goes to medical meetings. Notice I said *reads* books—which is quite different from simply buying books, for the latter may be only a sign of a loss of sales resistance or a sporadic outbreak of collectors' mania.

The journal man is also an uncommon type if we confine his reading to scientific subjects and do not count the comic strip and the sporting page or the market reports; i.e., medical economics. If he is a discriminating reader, he is probably very well posted and up-to-date; but he learns to discriminate in his reading only by going to meetings and talking things over. The volume of journal literature is so great and indiscriminate that the pure journal man like the pure book man breaks down if he must carry the whole load—and once broken down, generally the whole load is lost.

Now, the third type is the man who regularly attends the meetings and takes a part in the scientific progress of his local, state, and national society—of course, few achieve the last. If we exclude the society man who goes to meetings mainly for the golf tournament, you will find this type also not numerous—but the number will include most of the book men and the discriminating journal men.

Taking all three types together, they still constitute about one-third of the working medical profession. Now, this amounts to telling you that only a small proportion of doctors keep up after they are out in practice even though books, journals, and societies are available—so, what about the importance of the doctor's company?

I think it important to point out the usefulness —even necessity of—frequent liberal discussion of medical questions with companions. This has been your most useful form of study in classroom, laboratory and hospital. You may think that the school crowds you into flocks solely to kill many birds with few stones—but the truth is that com-

panionship of the conference is another good reason as well. It is probably not easy to keep this companionship. If it were easy, the problems of continuation schooling would be solved.

Why does the doctor shun companions when as a student they were so useful? Modesty or timidity (they may be indistinguishable), jealousy, intolerance, indolence—are some of the reasons. That meetings are a waste of time is rarely a reason—unless meetings are entirely controlled by medical politicians. No one is too good to be a member of his local medical society. If any doctor is actually better trained than his fellows, it is his duty to keep these less able companions and at the same time seek companions in larger fields; i.e., state and national.

Of the various vices that wreck medical companionship, intolerance is the most important to talk about. The others, indolence, jealousy, etc., are not helped by conversation. They are secret vices to be overcome by introspection. But intolerance is so insidious, so easily confused with rightness and discrimination—that I see fit to warn you about it. Medical societies were torn apart in considering the question if germs cause diseases or if vaccines prevent colds. In medical companionship, it is a fine art—but one that can be cultivated—to disagree without being disagreeable—to bring light into a controversy without the usual heat. And tolerance can be cultivated. It generally comes naturally with aging and the loss of vigor, but can also be acquired by youth which tries to see both sides of an argument.

In medical companionship, I am surprised how much I learn in the process of convincing the other person he is wrong—sometimes I have learned that he has been right in the first place. In this sort of company, the book man proves his book learning and the journal man learns discrimination.

Now, this all pertains to the medical company the doctor keeps—what about the other company? There is no "other" of primary importance. The true physician lives his life apart from other men, and mingles with other men only enough to understand them and to keep from becoming queer or inhuman. The doctor who is a joiner—who enters into social and financial competition with business men, sooner or later is in business—either the business of medicine or some business outside medicine such as investments or speculation.

My advice, therefore, is to shun certain companions just as ardently as you cultivate others. The professional man—preacher, teacher, artist or engineer—is the fitting companion of the doctor. Sometimes a philosopher appears in any walk of life and is an inspiring companion to the doctor; but the ardent money-maker is rarely found in any walk of life—he gallops or is driven by a man in livery. If the philosopher happens to be a law-maker or a statesman, all the better. Your companionship may determine matters of public health—as should be—instead of leaving it to mere politicians. I would not have you shun the man of wealth, if he actually has it. He is dependent on you for help and advice in what to do with wealth to get the most out of it. This is an important function of the intelligent medical man.

Therefore, look carefully to the selection of your company. Make it largely medical, and keep it so by tolerance and industry so that your skill may grow from meeting the skill of others. Shun the money-maker lest you become one. Cultivate the philosopher, because he needs you.

—OSMJ—

Nationwide Study of Fireworks Accidents Started July 5, By Health and Safety Groups

A nationwide study of the nature, cause and results of fireworks accidents was inaugurated July 5 by the American Museum of Safety in cooperation with public health authorities and safety organizations throughout the country.

The National Society for the Prevention of Blindness is credited with the enlistment of the cooperation of fireworks manufacturers and health and safety education organizations in this joint move to make the Fourth of July "a really glorious and safe Fourth".

According to Mr. Arthur Williams, president of the museum, his organization was impelled to undertake this study as the result of revelations developed in a preliminary inquiry made last year by the National Society for the Prevention of Blindness. This society found that 29 persons had died and that more than 3,000 had been seriously injured in fireworks accidents during the Fourth last year, and the weeks immediately preceding and following the Fourth.

Leading manufacturers of fireworks, through Pyrotechnic Industries, Inc., have not only made an unconditional grant to the Museum of Safety which will make possible a wholly objective study, but have agreed in advance to take steps for the elimination of those elements in fireworks manufacture which are shown by this study to be responsible for any serious hazard to life and limb.

The American Museum of Safety will seek to ascertain the name of every person injured in a fireworks accident this year, and to secure from this person, or from the doctor or hospital treating him, details of just how the accident occurred and with what results. Health commissioners and other public health officials, as well as hospitals, police chiefs, and safety councils, and the press are being urged to cooperate in this effort.

NEWS NOTES *of* OHIO

Columbus—Dr. Earl W. Euans has been reappointed chief surgeon of the United Commercial Travelers of America for the eighteenth consecutive year.

Lewisburg—Dr. Charles E. Mumma will begin the practice of medicine here on or about August 1.

Marion—Dr. Warren Sawyer, recent graduate of the School of Medicine, Western Reserve University, is associated with his father, Dr. Carl W. Sawyer, at the Sawyer Sanatorium, White Oaks Farm.

Tiffin—Announcement has been made of the recent wedding of Dr. Paul J. Leahy and Miss Mary Quinn, Erie, Pa.

Warren—Dr. R. B. Dobbins will represent the Trumbull County Medical Society on the Warren Community Forum for the ensuing year.

Arlington—Dr. H. W. Klewer recently established offices here.

Martins Ferry—Dr. James Arbaugh, has become associated with his brother, Dr. E. V. Arbaugh.

Toledo—Dr. J. L. Roberts of the Education Bureau of the Toledo Academy of Medicine, recently gave a radio address on "Cataract".

Zanesville—Dr. A. Curtis Ormond recently married Miss Anne Slingluff, Cambridge.

Marion—Dr. C. G. Smith has been chosen president-elect of the Ohio State Eclectic Medical Association. Dr. F. L. Thomas, also of Marion, is treasurer of the organization.

Salem—Dr. Seward Harris, Columbiana County health officer, recently addressed the Salem Rotary Club on the subject of "Sterilization".

Kent—Dr. J. C. Fiala, resident physician and surgeon at St. Thomas Hospital, Akron, for the past two years, has opened offices here.

Randolph—Announcement has been made of the marriage of Dr. A. J. Silbiger and Miss Evelyn Cheswick, Cleveland.

Fremont—Dr. C. R. Pontius recently began his 51st year in the practice of medicine.

St. Marys—Dr. W. V. Barton, formerly of Atlanta, Ga., and Hamilton, Ohio, has opened offices here.

Canton—Dr. Zed F. Atwell was elected junior vice-commander of the United Spanish-American War Veterans.

Peebles—Announcement has been made of the marriage of Dr. Robert B. Ellison and Miss Clarine Wickerham.

Painesville—"Sudden Death", was the subject discussed by Dr. Morris Carmody, Cleveland, at a recent meeting of the local Civitan Club.

Ironton—Dr. Esther Marting, daughter of Dr. W. F. Marting and one of three daughters who are physicians, has returned here to become associated with her father at the Marting Hosiptal.

Columbus—Dr. Hugh C. Thompson, formerly of Bexley, has become associated with Dr. Erwin W. Troutman.

Youngstown—The following physicians made radio addresses during the month of June: Dr. R. B. Poling, "Vacation Health"; Dr. Joseph Rosenfeld, "Relieving Hay Fever and Asthma"; Dr. Louis Deitchman, "Swimming Hazards", and Dr. J. D. Brown, "The Foolish Fourth".

Mt. Vernon—Dr. William T. Sharp, staff physician at the Ohio State Sanatorium, recently married Miss Lucille Dome, R.N., relief nurse at the sanatorium.

Lima—Dr. W. W. Beauchamp discussed "Sterilization" at the annual luncheon of the educational committee of the Allen County Child Welfare Association.

Orient—Dr. W. R. Hutchinson recently took over the office and equipment of Dr. Jacob Knight here, where he will continue the practice of medicine.

McArthur—Dr. Franklin Wills has opened offices here.

Millersburg—Dr. G. B. Faber, who formerly practiced in Fredericksburg and West Salem, and was with the State Industrial Commission for eight years, has opened offices here.

Troy—Dr. J. L. Paine, formerly of Dayton, has become associated with Dr. M. M. Brubaker here.

Cleveland—The following radio health talks, sponsored by the Health Education Committee of the Cleveland Academy of Medicine, were given during the month of June: Dr. H. J. Knapp, "Diphtheria Prevention"; Dr. H. V. Paryzek, "Tuberculosis"; Dr. D. M. Glover, "Plastic Surgery"; and Dr. H. D. Piercy, "Fatigue—That Tired Feeling".

Cincinnati—Dr. G. T. Willke, formerly medical director of the Kneipp Sanitarium, Rome City, Indiana, has located in College Hill and will practice medicine there.

Berne—Dr. Dailey Jones suffered severe injuries in an automobile accident near Ft. Wayne, Indiana.

Lakewood—Dr. John H. Tildes, formerly resident surgeon at Lutheran Hospital, Cleveland, has opened offices here.

Miamisburg—The residence, office and equipment of Dr. Charles T. Hunt, whose health necessitated his retirement a few months ago, have been purchased by Dr. David L. Hirst, Cincinnati, who is now practicing here.

Columbus—Dr. Russell G. Means was recently elected a director of the Chamber of Commerce.

Columbus—Three Columbus physicians recently honored in their respective fields are Dr. Albert D. Frost, who was elected to membership in the American Ophthalmological Society; Dr. George M. Curtis, elected to fellowship in the American Surgical Association, and Dr. Hugh G. Beatty, elected to fellowship in the American Laryngological, Rhinological and Otological Society.

Cleveland—Dr. Robert S. Dinsmore, Jr., was one of the speakers at the annual meeting of the Medical Alumni Association of Syracuse University held at Syracuse, N. Y., June 3-4. His subject was "Practical Aspects of Gall-Bladder Disease".

Toledo—Dr. William M. Meffley is spending three months in Europe. He will attend cancer clinics in Brussels and Louvain, Belgium, Paris, Berlin and the Radiumhemmet in Stockholm, Sweden.

Newark—Dr. Lewis A. Mitchell was granted a fellowship in The American College of Physicians at a meeting recently held in Philadelphia.

Haydenville—Dr. R. M. Anderson, Columbus, will take over the practice of Dr. J. D. Francis, who will enter the University of Illinois to study orthopedic surgery.

Steubenville—Dr. George F. Gourley recounted some of his adventures as a traveler, sportsman and fisherman at a recent meeting of the Steubenville Kiwanis Club.

Cincinnati—Dr. Robert Pollack, assistant house physician at General Hospital, has been appointed to active duty with the Medical Corps of the United States Army at Fort Thomas, Ky.

Cincinnati—Dr. Thomas R. Brown, associate professor of medicine, Johns Hopkins University, spoke at the annual meeting of Alpha Omega Alpha, recently held at the Academy of Medicine.

Niles—The Exchange Club was addressed by Dr. Sidney McCurdy, Youngstown, on "What Constitutes Health?"

Cleveland—Drs. C. L. Cummer, J. R. Driver, and E. W. Netherton of Cleveland, read papers at the annual meeting of the American Dermatological Association held at White Sulphur Springs, West Virginia.

Cleveland—Dr. John A. Toomey, Cleveland, was elected to active membership in the American Pediatric Society at its recent annual meeting.

— OSMJ —

The following promotions in the faculty of Western Reserve University School of Medicine, Cleveland, were recently announced:

Dr. Harry Goldblatt, to be professor of experimental pathology.

Edward Muntwyler, Ph.D., associate professor of biochemistry.

John P. Quigley, Ph.D., associate professor of physiology.

Dr. Theodore T. Zuck, assistant professor of anatomy.

Dr. Clyde L. Cummer, assistant clinical professor of dermatology and syphilology.

Dr. John W. Holloway, assistant clinical professor of surgery.

Dr. Arthur J. Horesh, assistant clinical professor of pediatrics.

Dr. Fred C. Oldenburg, assistant clinical professor of medicine.

Dr. Gaius E. Harmon, associate professor of hygiene and vital statistics, has resigned to become chief of the bureau of epidemiology of the Chicago Board of Health.

— OSMJ —

Dr. Jesse D. Hamer, Phoenix, Arizona, the new president-elect of the Arizona State Medical Association, was born in Ross County, Ohio, March 28, 1898; graduated from Wittenberg College, Springfield, in 1922, and received his doctor of medicine degree at the School of Medicine, Western Reserve University, in 1926.

— OSMJ —

One of the discussions at the 14th Annual Scientific and Clinical Session of the American Congress of Physical Therapy to be held at Kansas City, September 9 to 12, will be Dr. Ben L. Bryant, attending otolaryngologist, Good Samaritan Hospital, Cincinnati. His subject will be "Ionization in Hay Fever: Indications, Technic, Scope". Full particulars concerning the meeting and the instruction course may be obtained by addressing the American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago.

— OSMJ —

Dr. George W. Crile, Cleveland, and Dr. John E. Brown, Sr., Columbus, were among the speakers at the sixty-eighth annual convention of the West Virginia State Medical Association held at Wheeling, W. Va., May 6, 7 and 8.

DEATHS IN OHIO

J. W. Arbegast, M.D., Bellefontaine; Eclectic Medical College, Cincinnati, 1894; aged 78; died June 17, following a long illness. Dr. Arbegast practiced medicine in Logan County for 40 years. He was a member of the Masonic Order, the K. of P., I. O. O. F. and K. G. E. lodges, and the Lutheran Church. His widow survives.

Jacob Harper Bain, M.D., New Concord; Ohio Medical University, Columbus, 1902; aged 59; member of the Ohio State Medical Association and Fellow of the American Medical Association; died June 12, of a heart attack. Dr. Bain practiced 12 years in Bloomfield and 21 years in New Concord. He was president of the Board of Public Affairs in New Concord for many years, and chairman of the Board of Trustees of the United Presbyterian Church. Surviving are his widow, one son, Dr. J. Herbert Bain, resident physician in the Cincinnati General Hospital, four sisters and two brothers.

John H. Burnett, M.D., Fostoria; Eclectic Medical College, Cincinnati, 1881; aged 79; former member of the Ohio State Medical Association and the American Medical Association; died June 26, after a six month's illness. Dr. Burnett practiced in Rising Sun a number of years before moving to Fostoria. Surviving are his widow, one son, one daughter, one brother and a sister.

Irwin C. Carlisle, M.D., Cleveland; University of Wooster, Medical Department, Cleveland, 1875; aged 82; former member of the Ohio State Medical Association and the American Medical Association; died June 28. Dr. Carlisle practiced in Cleveland for 41 years, but retired a few years ago because of ill health. He was a member of the Presbyterian Church. He is survived by his daughter.

Albert E. Connell, M.D., Cleveland; Western Reserve University School of Medicine, Cleveland, 1904; aged 63; former member of the Ohio State Medical Association and the American Medical Association; died June 12, following a long illness.

R. D. A. Gunn, M.D., Oberlin; Western Reserve University, School of Medicine, Cleveland, 1887; aged 76; member of the Ohio State Medical Association and Fellow of the American Medical Association; died June 7. Dr. Gunn was the dean of Oberlin's medical fraternity and well-known throughout northern Ohio. He began the practice of medicine in Cleveland, and moved to Oberlin in 1905. He was active in the work of First Church and East Oberlin Church, and was a leader in the prohibition movement. At the June meeting of the Lorain County Medical Society appropriate resolutions were adopted and a tribute paid to Dr. Gunn by Dr. G. C. Jameson, Oberlin. Surviving are his wife, one daughter and three sons.

Harrie E. Hard, M.D., Seville; Western Reserve University School of Medicine, 1898; aged 64; former member of the Ohio State Medical Association and the American Medical Association; died June 24, of pneumonia. Dr. Hard began the practice of medicine in Medina, later moving to Seville, where he practiced for 34 years. He served four terms as coroner of Medina County. He was a prominent musician, having played in the original Cleveland Symphony Orchestra, and was a member of the Masonic Lodge. Surviving are his widow and a sister.

Philip Hawk, M.D., Zaleski; Starling Medical College, Columbus, 1892; aged 73; died July 5, following a long illness. Dr. Hawk retired six months ago because of ill health. He is survived by his widow.

Walter H. Lucas, M.D., Lakewood; Western Reserve University School of Medicine, Cleveland, 1893; aged 62; died July 5, after a year's illness. Dr. Lucas retired two years ago, after practicing in Lakewood for nearly 40 years. Surviving are his widow, a daughter and two sons.

Carlton S. L. McCullough, M.D., Steubenville; University of Maryland School of Medicine, 1923, and College of Physicians and Surgeons, Baltimore; aged 41; member of the Ohio State Medical Association and the American Medical Association; died June 18, of coronary thrombosis. Dr. McCullough was a native of Washington County, Pa., but he practiced in Steubenville and Follansbee for the past 12 years. He came from a family of physicians, his father in Oakdale, Pa., two brothers in Washington, Pa., and another brother in Pittsburgh, Pa., all being physicians. He was a member of the Westminster Presbyterian Church. Surviving are his son, his parents, three brothers and a sister.

Clyde W. Mummert, M.D., Columbus; Ohio Medical University, Columbus, 1903; aged 64; member of the Ohio State Medical Association and Fellow of the American Medical Association; died July 5. Dr. Mummert practiced in Columbus for 32 years. He was a member of the Masonic Lodge, and the South Congregational Church. Surviving are his widow, a son, a brother and two half-brothers.

Clarence W. Orr, M.D., Cincinnati; Miami Medical College, Cincinnati, 1883; aged 78; died June 10. Dr. Orr started the practice of medicine

in Cicero, Ind., later moving to Price Hill, Cincinnati, where he practiced for 49 years. He was a member of the Masonic Lodge. Surviving are his son and a brother.

Frank H. Parker, M.D., Rutland; Columbus Medical College, 1880; aged 78; died June 2, from a heart attack. Dr. Parker retired a few years ago, after practicing in Meigs County for many years. He is survived by his widow.

Thomas H. Remy, M.D., Ironton; Miami Medical College, Cincinanti, 1895; aged 68; member of the Ohio State Medical Association and the American Medical Association; died June 11 after an extended illness. Following a few years' practice in Getaway, Hanging Rock and Marion, Dr. Remy located in Ironton, where he was prominent in civic affairs. At the time of his death, he was president of the City Board of Health. He was an active member of the Masonic and K. of P. Lodges, and the First Baptist Church. Surviving are his widow, a brother and two sisters.

William Jones Thomas, M.D., Ravenna; Western Reserve University School of Medicine, 1898; aged 65; member of the Ohio State Medical Association and Fellow of the American Medical Association; died June 24, following a splenectomy. Dr. Thomas practiced in Portage County for 30 years, being located in Palmyra before going to Ravenna in 1917. He was a member of the staff of Robinson Memorial Hospital, Ravenna. Surviving are his widow and three sons.

Dempsey L. Travis, M.D., Cleveland; University of Wooster, Medical Department, Cleveland, 1878; aged 80; member of the Ohio State Medical Association and the American Medical Association; died June 30, following a long illness. Dr. Travis was chief medical officer for the Cleveland fire department from 1887 until his retirement in 1931. Surviving are his widow, a son and a daughter.

John A. Turner, M.D., Cincinnati; University of Illinois, College of Medicine, Chicago, 1909; aged 52; member of the Ohio State Medical Association and the American Medical Association; died June 19, after an illness of three weeks. Dr. Turner was medical director of the Worthington Pump and Machinery Corporation from 1925 until 1932, when that firm moved its plant to Buffalo, N. Y. Since that time he had been engaged in industrial practice for a number of Cincinnati companies. Prior to 1925, he was in public health work in Washington. He was a member of the Masonic Lodge, Kiwanis Club and the Church of the Good Shepherd. Surviving are his widow, a brother and four sisters.

Marion W. Uberroth, M.D., Tiffin; College of Physicians and Surgeons, Baltimore, Md., 1893; aged 63; member of the Ohio State Medical Association and Fellow of the American Medical Association; died July 7, from a heart attack. Dr. Uberroth had practiced in New Riegel and Tiffin for 42 years. Surviving are his widow, a son and a daughter.

Louis H. Wagner, M.D., Cleveland; Cleveland Medical College, Homeopathic, Cleveland, 1897; aged 64; member of the Ohio State Medical Association and Fellow of the American Medical Association; died July 2, following a brief illness. Dr. Wagner practiced on the East Side of Cleveland for more than 35 years. He was a member of the Masonic and K. of P. lodges. Surviving are his widow and three sons.

Robert H. Whallon, M.D., Cincinnati; Bellevue Hospital Medical College, New York, 1886; aged 81; former member of the Ohio State Medical Association and the American Medical Association; died June 18, after a lingering illness.

John W. Whitsett, M.D., Hannibal; University of Pittsburgh School of Medicine, 1903; aged 59; former member of the Ohio State Medical Association and the American Medical Association; died June 24, from a skull fracture suffered when struck by a truck in Worthington. Surviving are his widow and a son.

Shelby L. Wise, M.D., Galena; Columbus Medical College, 1884; aged 77; died July 6. Dr. Wise, a native of Johnstown, had practiced in Galena and Center Village for 51 years.

KNOWN IN OHIO

John G. Williams, M.D., Brownsville, Texas; Miami Medical College, Cincinnati, 1892; aged 67; former member of the Ohio State Medical Association and the American Medical Association; died July 2, of heart disease. Dr. Williams took over the practice of his father, the late Dr. Peter M. Williams, in Westwood and Cheviot, suburbs of Cincinnati, in 1892, and continued there until his retirement in 1926. He then moved to Chicago and later to Brownsville, Texas. He was a member of the Masonic Lodge. Surviving are his widow and a son, Dr. Foster M. Williams, Westwood.

—OSMJ—

—Anonymous gifts totaling $22,000 will make possible the establishment of a complete, modern urologic unit at the Cincinnati General Hospital, Dr. Alfred Friedlander, dean of the Medical College of the University of Cincinnati, recently announced. It is hoped that the unit will be finished in time for the fall opening of the Medical College. Heading the new unit will be Dr. Gordon F. McKim and Dr. Parke G. Smith, professor and assistant professor, respectively, of urology at the College of Medicine of the University of Cincinnati.

COUNTY SOCIETIES *and* ACADEMIES

First District

Adams County Medical Society met at the West Union Court House, Wednesday evening, June 26. The following program was presented: "Surgical Treatment of Lesions of the Gastro-Intestinal Tract", by Dr. William B. Morrison, Columbus; "Mumps", by Dr. Sam Clark, Cherry Fork; "Trans-Urethral Resection of the Prostate Gland", by Dr. Frank W. Harrah, Columbus.—*O. T. Sproull, M.D., Secretary.*

Butler County Medical Society was addressed by Dr. John A. Caldwell, Cincinnati, President of the Ohio State Medical Association, on "Acute Traumatic Bone Atrophy", at its regular monthly meeting held at Mercy Hospital, Hamilton, June 12. Drs. Z. P. Zerfass and Vernon Roden were appointed medical advisors to the county relief director.—News Clipping.

Clermont County Medical Society participated in the ceremonies honoring Dr. W. E. Thompson, Bethel, on his 100th birthday, July 6.—*J. M. Coleman, M.D., Secretary.*

Clinton County Medical Society held its regular monthly luncheon meeting, Tuesday, July 2, at the Bindley Hotel, Blanchester, with nearly a full membership present. Dr. Joe Heiman, Jewish Hospital, Cincinnati, presented an interesting paper on "Uterine Bleeding."—*Elizabeth Shrieves, M.D., Secretary.*

Highland County Medical Society met at the Parker House Hotel, Hillsboro, Thursday, June 5. The guest speaker was Dr. Wells H. Teachnor, Jr., Columbus, who spoke on "Mesenteric Adenitis".—News Clipping.

The July meeting of the Highland County Medical Society was held at the Parker House Hotel, Wednesday, July 4. Dr. Vernon E. Stewart, Cincinnati, showed colored motion pictures depicting disease conditions and surgical technique.—News Clipping.

Second District

Greene County Medical Society met at Xenia, Wednesday, July 3. Dr. F. William Cox, Dayton, talked about "Common Diseases of the Lower Third of the Colon". He reviewed the essential anatomy, emphasizing the need for all practitioners to keep these diseases in mind, and gave a concise resume of practical methods of care. The average attendance at society meetings this year has been 20, with an active membership of 37.—*Reyburn McClellan, M.D., Secretary.*

Third District

Auglaize County Medical Society met in bimonthly session at Minster, Thursday evening, June 27, with an attendance of twenty-five, including several visitors from Sidney, Piqua and Lima.

The program consisted of an Obstetrical Symposium, participated in by Dr. E. F. McCampbell and Dr. S. J. Goodman, both of Columbus, Ohio, and several local members.

Dr. McCampbell's subject was "Heart Disease in Pregnancy", considered in the light of (1) The Effect of Heart Disease on Pregnancy; and (2) The Effect of the Pregnancy on Heart Disease. Dr. Goodman discussed "Common Toxaemias of Pregnancy", limiting his consideration to (1) Vomiting, (2) Eclampsia, and (3) Puerperal Sepsis. He suggested several characteristically practical and reasonable methods of treatment of these conditions. An enjoyable social hour followed, with palatable refreshments served with usual Minster hospitality.—*Chas. C. Berlin, M.D., Secretary.*

Fourth District

Defiance County Medical Society met at Defiance Hospital, Tuesday, May 28, and at the same place, Tuesday, June 25. The speaker at the May meeting was Dr. S. R. Salzman, Toledo, who discussed, "Encephalitis, Secondary to Gall-Bladder Diseases". Dr. Franz E. Solier, Bryan, spoke at the June meeting on "Back Pains", using *X*-ray plates.—*H. B. Wideman, M.D., Secretary.*

Wood County Medical Society was entertained by the Toledo East Side Hospital staff on Thursday, June 20. A golf tournament, dinner and entertainment at the Chippewa Golf Club, were followed by motion pictures of the last Wood County Clinical meeting.—News Clipping.

Fifth District

Trumbull County Medical Society met at the Warren Country Club, Wednesday, June 19. Dr. Milton Cohen, Cleveland, presented a paper on "Allergic Influences on Diseases".—News Clipping.

Sixth District

Summit County Medical Society held its annual outing and Ladies' Day at the Congress Lake Country Club, Akron, Wednesday, July 31.—Bulletin.

Seventh District

Belmont County Medical Society was addressed by Dr. R. H. Wilson, Martins Ferry, at a meeting held at the Barnesville Community Hospital, Thursday, June 26.—News Clipping.

Tuscarawas County Medical Society met at the New Philadelphia city council chamber, Thursday, June 13th. Papers on the "Eye" were pre-

sented by Dr. Roy Wilson, Dennison; Dr. S. H. Winston, Dover; Dr. Fred Bower, Uhrichsville. The papers were discussed by Dr. J. F. Douthitt, Dover; Dr. Morris W. Everhard, New Philadelphia, and Dr. Max Shaweker, Dover.

The July meeting of the society was held at the residence of Dr. Jay Calhoun, Uhrichsville, Thursday, July 11. Dr. Charles A. Doan, Director of Research, College of Medicine, Ohio State University, presented a program on "Anemia".—Bulletin.

Eighth District

Fairfield County Medical Society held a luncheon meeting, Wednesday, June 5, at the Hotel Martens, Lancaster. The speaker was Dr. Lecklitner, University of Iowa.—News Clipping.

Fairfield County Medical Society met at the Hotel Martens, Lancaster, Tuesday, May 21. M. W. Johnson, county relief director, spoke on the medical phase of relief work.—News Clipping.

Guernsey County Medical Society was entertained by the staff of Swan Hospital, Cambridge, Thursday evening, July 4, with a reception and picnic dinner on the grounds of the hospital—News Clipping.

Ninth District

Hocking County Medical Society held its regular meeting at Cherrington Hospital, Logan, Thursday, May 9. Dr. J. D. Francis, Haydenville, discussed "Arthritis".—News Clipping.

Scioto County—The regular monthly meeting of the Hempstead Academy of Medicine was held at the recreational hall, Nurses' Home, Portsmouth, Monday evening, July 8. Dr. S. L. Meltzer, Portsmouth, discussed "*X*-ray and Radium Treatment of Malignancies".—*William E. Scaggs, M.D., Secretary.*

Tenth District

Knox County Medical Society meeting at the Alcove, Mt. Vernon, Thursday, May 24, was addressed by Dr. H. O. Studley and Dr. A. F. Beam of the staff of Lakeside Hospital, Cleveland.—News Clipping.

Ross County Medical Society was addressed by Dr. E. H. Chapin, Columbus, at its regular meeting at Dun Glenn Manor, Chillicothe, Thursday, May 2.—News Clipping.

—OSMJ—

Annual Meeting of 8th District Held June 20 at Rocky Glen

The annual meeting of the Eighth District of the Ohio State Medical Association was held at the Rocky Glen Sanatorium, McConnellsville, June 20, with a large number of physicians from the counties in the district attending.

Following the address of welcome by H. A. Phillips, superintendent of the sanatorium, Dr. D. G. Ralston, presided during a short program and business session. Brief talks were made by Dr. E. R. Brush, Zanesville, Councilor of the Eighth District; Dr. Louis Mark, Columbus, medical director of Rocky Glen Sanatorium; Dr. Walter H. Hartung, Columbus, State Health Director; Dr. Andrew Timberman, Columbus, and Dr. Lee Humphrey, Malta, member of the State Medical Board.

The scientific program was opened by Dr. Wm. E. Lower, surgeon at the Cleveland Clinic Hospital, who discussed "Management of Benign Prostatic Hypertrophy".

Dr. Jonathan Forman, Grant Hospital, Columbus, spoke on "Allergy in General Practice".

"The Treatment of Empyema with Special Reference to the Chronic Case", was discussed by Dr. Willard Van Hazel, professor of surgery of the University of Illinois Medical School.

Dr. M. E. Blahd, director of Surgery, Mt. Sinai Hospital, Cleveland, presented a paper on "Peptic Ulcer and Its Surgical Management".

The scientific session was concluded by Dr. A. A. Tombaugh, resident physician at the sanatorium, who discussed "Collapse Therapy of the Lungs".

Officers elected for the ensuing year are Dr. Arthur B. Smith, president; and Dr. James B. Penrose, secretary, both of Marietta.

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HOSPITAL NOTES

—Staff officers and appointments at Good Samaritan Hospital, Cincinnati, have been announced as follows:

Fellowships in surgery: Drs. Charles H. Moore, Edward J. Bender, and Herbert L. Brinker.

Medical residents: Drs. Michael Ryan Barrett and August F. Fath.

Interns: Edward J. Devins, Eugene L. Huwe, George W. Yauger, and F. William Vockell, Cincinnati; Robert G. Hunter, Fort Thomas, Ky., and John J. Kearney, Wilkensburg, Pa., all of the University of Cincinnati Medical School; John A. Lampe and J. William Joseph, Cincinnati, and John J. Shea, Dayton, Ohio, all of St. Louis University Medical School; John H. Dornheggen, Cincinnati, Loyola University Medical College, Chicago; Lin S. Felder, Orangeburg, S. C., State Medical College, Charleston, S. C., and John K. Jackson, Aurora, Ind., Indiana University Medical School, Bloomington, Ind.

—Seven resident physicians have been appointed to the staff of Children's Hospital, Cincinnati for the ensuing year. Dr. Robert R. McDonald, graduate of the University of Pittsburgh, is the chief resident physician. His assistants are: Dr. Barbara Ann Howell, Vanderbilt Medical School; Dr. Carolina P. Scott, University of Pennsylvania; Dr. George S. Frauenberger, University of Michigan; Dr. Masters H. Moore, Tulane University; Dr. Robin M. Overstreet, University of Pennsylvania, and Dr. William McPetty, University of Pittsburgh.

—The following appointments to the staff of Miami Valley Hospital, Dayton, were recently announced: Dr. H. W. Kendell, Covington; Dr. F. A. King, Benton Harbor, Mich.; Dr. R. D. Snyder and Dr. W. K. Gregg, Dayton, resident physicians. Dr. W. B. Taylor, Jackson; Dr. R. A. Smith, Tiffin; Dr. C. E. Clark, Springfield; Dr. R. W. Tapper, Dayton, Dr. Paul Troop, Dayton; Dr. M. Oosting, Holland, Mich.; Dr. R. J. English, Grand Rapids, Mich., and Dr. W. H. Hanning, Dayton, interns.

—Recent appointments to the staff of Good Samaritan Hospital, Dayton, are the following: Dr. Louis Loeber, Dayton, house physician; Dr. Frank Wenzke, Celina; Dr. Attillio Rizzolo, New York City; Dr. Katherine Ver, Dayton, and Dr. J. M. Duchak, Dayton, interns.

—The following interns have joined the staff of St. Elizabeth Hospital, Dayton: Dr. C. S. Baldwin, Mt. Vernon; Dr. E. L. McCall, Montecello, Florida; Dr. R. C. Miller, Dayton; Dr. J. F. Mills, Cincinnati; Dr. S. F. Turner, Galveston, Texas; and Dr. T. S. Rosen, Cleveland.

—Operating rooms at Mount Sinai Hospital, Cleveland, now are equipped with air-conditioning.

—A special election will be held in Lawrence County August 13th to vote on a three-tenths mill levy to provide approximately $135,000—the county's share of the cost of a new county hospital. It is reported that the balance—$115,000—will be donated by the Federal Government, if the bond issue is approved by the electorate.

—Muskingum County commissioners have appropriated $25,000 towards the cost of a new county tuberculosis sanatorium. Actual expenditure of the amount appropriated is dependent on the Federal Government's decision on a request for $75,000 additional to complete the 50-bed structure.

—A 15-acre tract of land has been purchased by the Jewish Consumptive Relief Society, Cleveland, as the site for a tuberculosis convalescent home.

—An elevator, made possible through a gift of $10,000 from Mrs. C. F. Whisler, will be installed at the Hillsboro Hospital.

—A complete emergency unit, including a fracture room and equipment for providing casts, was recently dedicated at Aultman Hospital, Canton, in memory of Dr. Robert T. Shipley, a member of the staff, who died about a year ago. The memorial was contributed by friends of Dr. Shipley.

—The following resident physicians and interns assumed their new duties in Cincinnati hospitals July 1:

GENERAL HOSPITAL

Drs. Ben Felson, Julius Gelperin, Fred Goldman, Sander Goodman, Isaac Kawasaki, Joseph R. Kahn, Meyer Kurzner, John R. McBride, M. Louis McGowan, Cecil D. McIntire, William P. Montanus, David A. Nathan, Virgil Plessinger, Laurence M. Quill, Leon Saler, Matthias F. Strashun, George H. Wadsworth and Armine T. Wilson, all of the University of Cincinnati Medical College; Drs. Nina A. Anderson, University of Minnesota; Drs. W. A. Bishop, Jr., Baylor University, Dallas, Tex.; J. H. Carlock, Jr., Tulane University, New Orleans; James Chambers, University of Texas, Galveston; Sherman J. Deur, University of Iowa, Iowa City; George Flenner, Cornell University; J. F. Foertner, Yale; James W. Hawkins, Harvard; W. B. Herter, Yale; James B. Irwin, Johns Hopkins, Baltimore; C. M. Lee, Jr., University of Virginia; Curtis J. Lund, University of Wisconsin; Harlan McGregor, Ohio State University; Richard McIlroy, Washington University, St. Louis; Marcus J. Magnussen, Iowa; Wilfred N. Sisk, Wisconsin; Harrison J. Shull, Vanderbilt University, Nashville, Tenn., and Robert Sparkman, Baylor University.

CHRIST HOSPITAL

The two resident physicians who began their new work at Christ Hospital were Dr. H. C. Boehner and Dr. John A. Debold, resident physicians. Dr. Charles E. Work, and Drs. Charles A. Castle, J. Edward Hershberger, Carroll C. Johnson, Stewart R. Jones, J. Risk Meek, W. Riddle, John H. Siehl and Andrew J. Weiss, all of University of Cincinnati Medical College, interns.

JEWISH HOSPITAL

Dr. Walter E. Felson, University of Cincinnati Medical College and Dr. Bela Klein, Breslau, Germany, residents in medicine, and Dr. Alfred Lustberg, Vanderbilt University, Nashville, Tenn., and Dr. Lloyd Hishich, University of Cincinnati Medical College, residents in surgery.

Drs. Samuel Reingold, David Brown, Bernard Safer, Herbert Warm, Herschel Sachs, Harry Dworkin and Samuel Rockwern, all of the University of Cincinnati Medical College; Dr. Harry Cohen, University of Kansas, and Dr. Walter Brown, Berlin, Germany, interns.

ST. MARY HOSPITAL

Dr. Gerald A. Foster, Dr. Philip J. Holobach, Dr. John Edwin Reed, Dr. Charles C. Lemort and Dr. Raymond M. Carmichael, all of the College of Medicine, University of Cincinnati, interns.

—Announcement is made of the following appointments of resident physicians, assistants and interns to University hospitals, Cleveland, for the year beginning July 1:

Pediatrics—Resident, Dr. W. George Sumner; assistant residents, Drs. Patrick J. Maloney, Bernard B. Lilien and Edwin R. Watson; interns, Drs. Robert P. Fulton, Orien B. Patch, Carl F. Wagner and Paul C. Crone.

Obstetrics—Assistant residents. Drs. Otis E. Marler, Elmer T. Coates and S. F. Moore.

Medicine—Resident, Dr. Maurice Sullivan; assistant resident, Dr. Paul G. Reque; interns, Drs. Alfred P. Thom III, Paul M. Glenn, Estelle M. McNiece, James J. Badal and Francis F. Hill.

Surgery—Resident. Dr. Delbert M. Hand; interns, Drs. Bert Bradford, Jr., John A. Clark, Charles I. Thomas, R. L. Gettman, James L. Hanley, Kenton R. Phelps, John A. Murphy, John W. Hobson and Robert W. Dennis.

Gynecology—Assistant resident, Dr. R. A. McCurdy.

Pathology—Assistant resident. Dr. William B. Wartman; intern, Dr. Howard C. Jackson.

—The following new interns are now on duty at the Springfield City Hospital: Dr. Ray M. Turner, Ohio State University; Dr. John Robert Scherer, Ohio State University; Dr. Howard Ingling, Western Reserve University; Dr. George M. Crow, Georgetown Medical School; Dr. Clark Ellis, Ohio State University, and Dr. R. Milton May, Indiana University.

—The following interns have been appointed to the staff of North and South Side Units of the Youngstown Hospital: Dr. John A. Renner, University of Colorado; Dr. Herman Ipp, Ohio State University; Dr. James K. Herald, University of Maryland; Dr. E. L. McDougal, Western Reserve University; Dr. Vernon L. Goodwin, Western Reserve University; Dr. H. L. Bookwalter, Western Reserve University; Dr. Allan A. Baldwin, University of Cincinnati; Dr. L. L. Hall, University of Colorado; Dr. John A. Welter, University of Iowa; Dr. Adam J. Earney, University of Wisconsin; Dr. John A. Rogers, University of Rochester, and Dr. James Hamilton, Oklahoma University.

—Announcement has been made of the appointment of Dr. George T. Flecher, Ravenswood, W. Va., as resident physician at White Cross Hospital, Columbus. The following interns joined the staff July 1: Dr. Fred E. Spangler, Somerset, Ohio State University; Dr. David B. Lewis, Lilly Chapel, Ohio State University; Dr. Edwin H. Artman, Piqua, Ohio State University; Dr. Philip J. Woodworth, Athens, Univeristy of Cincinnati; Dr. Richard H. Wehr, Caldwell, University of Louisville, and Dr. John P. Urban, Columbus, Ohio State University.

—Dr. George I. Baumann was recently appointed orthopedic surgeon to the staff of Fairview Hospital, Cleveland.

—Dr. Donald Rehbock, formerly of City Hospital, Cleveland, has succeeded Dr. Paul Gross, as pathologist at Charity Hospital.

—Dr. H. M. Clodfelter, formerly of the Cleveland Clinic, has joined the staff of Mercy Hospital, Columbus.

—The following recent medical graduates began their intern training at Grant Hospital, Columbus, July 1: Dr. Richard L. McFarland, Columbus; Dr. A. J. Payne, Ironton; Dr. R. G. Plummer, Columbus; Dr. D. J. Mullholand, McCutchenville, all graduates of Ohio State University College of Medicine; Dr. W. G. Fischer, Scio, Washington University, St. Louis, Mo.; Dr. N. M. Newport, Oklahoma City, Okla., University of Oklahoma; Dr. Pauly Baird, Gallipolis, Tulane University, and Dr. Grape F. Keller, Oklahoma City, Okla., University of Oklahoma.

—New resident physicians at Columbus Children's Hospital are Dr. Victor Kolb, Ohio State University College of Medicine; Dr. Gene Haber, Rush Medical College, Chicago; Dr. Fred Roacke, George Washington University Medical School.

—Dr. John C. Danahy has been appointed assistant pediatrician on the staff of St. Mary Hospital, Cincinnati.

—Dr. C. S. Woods, superintendent of St. Luke's Hospital, Cleveland, has announced the appointment of the following new internes and resident physicians for the year beginning July 1:

Internes: Francis Spearman Adams, Jr., Northwestern University; Henry E. Baum, University of Chicago; Louis F. Cleary, Western Reserve; Harry E. Crimm, Western Reserve; Baxter T. Davies, McGill University; Lincoln C. Dickey, Western Reserve; John D. Gordinier, Tulane; James F. Jones, Harvard; Karl F. Kaufman, Ohio State; Donald A. Kelly, Western Reserve; Andrew J. Lamb, Jr., Western Reserve; Charles G. Polan, University of Chicago; Arthur A. Presti, George Washington University; Arthur E. Wentz, Ohio State.

Resident Physicians: Lance C. Price, medicine; John J. Monfort, surgery; Harold F. Burkons, obstetrics; James V. Stewart, otolaryngology; and Alex Gross, pathology.

Thomas W. Watson, assistant in medicine; John A. Topinka, first assistant in surgery; Seeley N. Gray, second assistant in surgery; Alfred D. Miessner, third assistant in surgery; William A. Avery, assistant in obstetrics; Benjamin M. Avellone, assistant in otolaryngology, and Harold G. Pritzker, assistant in pathology

—New *X*-ray equipment and films costing $41,000 were recently purchased by Cleveland for the use of City Hospital.

—Dr. D. F. Gerber has been elected president of the medical staff of the Middletown Hospital. His associates are: Dr. W. H. Henry, vice-president, and Dr. W. A. Reese, secretary. Dr. C. T. Atkinson is the retiring president.

—Abandoned in 1928 for a new structure, the old Clinton County Infirmary may be rebuilt and converted into a tuberculosis hospital for patients from Clinton, Greene and Warren counties, according to plans recently announced by commissioners of the three counties.

CLASSIFIED ADVERTISEMENTS

Rates for advertisements under this heading are 50 cents per line, payable in advance. Minimum charge of $1.00 for each insertion. Price covers the cost of remailing answers. Forms close 16th of the month preceding publication.

For Sale—General practice and complete office equipment of Dr. William J. Thomas, deceased, June 24th. County seat—population 8,500. On staff of new County Hospital. Address Mrs. Wm. J. Thomas, Ravenna, Ohio.

HEAT STERILIZATION— A BASIC PRINCIPLE OF CANNING

● The Frenchman, Appert, is given credit for the first application of heat sterilization as a means of food preservation.

Competing for a prize of 12,000 francs offered by Napoleon for the most practical method of food preservation for blockaded France, Appert, in 1804, laid the foundations of the modern canning industry. So successful were his limited efforts that a contemporary food critic has stated that Appert's products recalled "the month of May in the heart of winter."

In the first English edition of his text (1) Appert propounds his conviction:

> "That the application of fire in a manner variously adapted to various substances, after having with the utmost care and as completely as possible, deprived them of all contact with the air, effects a perfect preservation of those same productions, with all their natural qualities."

Appert's findings were made empirically years before the true causes of food spoilage were known. Today, it is evident that the success of his procedure was due to heat destruction of spoilage micro-organisms, such as are associated with raw foods, and protection from subsequent contamination by such organisms.

The sterilization procedure, or the "process" as it is termed in the industry, is an integral part of commercial canning. Essentially, it involves the heat treatment of foods sealed in hermetic containers after proper preparation; the preparatory procedures accomplishing, among other things, the removal of most of the air from the can.

The time and temperature required for sterilization of a food are dependent upon many factors. The establishment of proper processes for canned foods is not a haphazard procedure; scientific methods constantly refined during the past two decades serve to determine the times and temperatures which must be used.

The findings of the physical chemist as to the rate of penetration of heat into the food are combined mathematically with data obtained by the bacteriologist on the thermal resistance of spoilage micro-organisms (2).

From this calculation are determined the proper processes necessary to destroy spore-forming spoilage bacteria whose thermal resistance are much greater than those of the pathogens.

Selected raw material, proper preparation, and scientifically determined methods of heat sterilization have combined to insure that canned foods as a class are among the most wholesome foods coming to the American table (3).

AMERICAN CAN COMPANY

230 Park Avenue, New York City

(1) The Art of Preserving, M. Appert, Black, Parry and Kingsbury, London, 1811.

(2) Thermal Process Time for Canned Foods, C. O. Ball, Natl. Res. Council Bulletin, v. 7 No. 37, 1923

(3) Preventive Medicine and Hygiene, M. J. Rosenau, Appleton-Century, N. Y. 5th Ed. 1927.

This is the third in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

Fraud Order Issued Against Ritholz Optical Concerns

Inasmuch as the Ritholz Companies have been doing business in Ohio, operating spectacle-fitting concerns under various trade names, readers of *The Journal* will be interested in an article published in the July 6 issue of *The Journal of the A.M.A.*, concerning the fraud order issued May 3, 1935, by the Postmaster-General, against certain Ritholz Companies.

In November, 1934, several companies operated by members of the Ritholz family were asked by the postal authorities to show cause by December 10, 1934, why a fraud order should not be issued against them. The hearing was held on February 10, 1935. Karl A. Crowley, solicitor for the Post Office Department, declared the evidence showed that the scheme operated by the defendants was one for obtaining money through the mails by means of false and fraudulent pretenses, representations and promises.

Solicitor Crowley's description of the Ritholz activities showed that the firm was started in December, 1919, under the name of the "Chicago Spectacle House", which sold, through the mails, spectacles, watches and other articles. Subsequent efforts on the part of the Post Office Department in 1921, 1922, 1925, 1928 and 1932 to curb the alleged swindles by these companies only resulted in apparently unfulfilled promises to discontinue the objectionable practices.

In summarizing the evidence presented in his charge of November, 1934, the solicitor stated that the Ritholz concerns solicited and obtained remittances of money through the mails by fraudulently representing that they took all the risk, when, as a matter of fact, the customer took the risk. The evidence showed, further, that the so-called "Scientific Self-Tester" that the Ritholz people sent to prospective customers was neither scientific nor based on sound principles. The evidence also showed that although the Ritholz concerns claimed to have "perfected a system of fitting glasses by mail", Benjamin Ritholz himself conceded at the hearing that glasses cannot be fitted by mail. While the principal contention of the Ritholzes in the case was that their customers got exactly what they ordered, the postal authorities stated that the evidence showed conclusively that the customers did not get what they had been led to believe they would get or what they ordered.

In concluding its report on the Ritholz frauds, the Bureau of Investigation of the A.M.A. makes the following statement: "During the past year or two the Ritholz concern, in addition to its mail-order quackeries has opened a number of retail stores. There are more than a dozen such stores in Chicago alone. Thanks to the ener-

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getic action on the part of the Chicago Better Business Bureau, all Chicago newspapers and radio stations have barred their columns and facilities to the advertising of the Ritholz stores. The street cars of Chicago are not so particular; they still carry blatant advertisements of the Ritholz retail establishments."

PUBLIC HEALTH NOTES

—Health educational talks sponsored by the State Department of Health are broadcast regularly each Tuesday afternoon at 2:30 o'clock over WOSU, Columbus. Mrs. Mary S. Cartwright has a series of broadcasts over the same station at the same time each Monday afternoon, and at 4:15 each Wednesday afternoon over Station WAIU Columbus.

Subjects discussed on the Tuesday afternoon broadcasts during July were: "Perils of the Fourth", by Dr. R. W. DeCrow, Chief, Bureau of Health Organization; "Poliomyelitis", by Dr. P. L. Harris, Medical Inspector; "Roadside Sanitation and the Traveling Public", by Major C. S. Slade, Assistant Sanitary Engineer.

Among the subjects presented by Mrs. Cartwright during July were: "Jenner, the Father of Vaccination", "Pasteur, and the Beginnings of Preventive Medicine", "Walter Reed and his Mosquito Researches".

—A program to save lives of infants through prevention of gastroenteritis is being carried on in West Cincinnati under direction of the City Board of Health, County Welfare Department, Public Health Federation and the Cincinnati Academy of Medicine. Private physicians and representatives of staffs of the Infant Welfare Clinic, Babies Milk Fund Association, Shoemaker Center and the United Jewish Social Agencies are cooperating in the work. F. E. R. A. funds provide 20 special nurses and two clerks to assist in the program.

—Physicians and public health officers of Northwestern Ohio held a district meeting at Van Wert, June 8, with Dr. C. R. Keyser, Van Wert, president of the district group, presiding. The State Department of Health was represented by Dr. W. H. Hartung, Director; J. E. Bauman, assistant director; Dr. R. W. DeCrow, of the Bureau of Health Organization, and Mrs. Clara E. Reeder, Bureau of Hospitals.

—The Jefferson County Medical Society recently cooperated with the Steubenville Municipal Health Department and the school health service in conducting a pre-school health examination clinic.

—Dr. R. M. Anderson, Haydenville, has been appointed to the Hocking County Health Board.

—Prevention of Fourth of July accidents by the enactment of ordinances to restrict the sale and

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use of fireworks in Cincinnati has been endorsed by the Cincinnati Academy of Medicine.

—Data compiled by the State Department of Health shows an alarming increase in Ohio's mortality record from heart disease. The increase was from 151.7 per 100,000 population in 1910 to 240.55 in 1934. While the population of the state has increased 46.8 per cent during this period, the increase in deaths from heart disease jumped 133.5 per cent. From 1910 to 1934, the total fatalities from heart disease in Ohio were 292,679.

—The National Tuberculosis Association gives the following report of tuberculosis deaths per 100,000 population in Ohio cities:

	1934	1933	% Gain or Loss
Cincinnati	96	94	+ 2
Cleveland	68	66	+ 3
Akron	35	34	+ 3
Dayton	57	83	—31
Columbus	86	75	+15
Toledo	66	67	— 1

—Children of pre-school age totaling 271, were recently given medical examinations at the annual clinic conducted by the Marion Board of Health in conjunction with the Parent-Teachers' Association and the Marion Academy of Medicine.

—Dr. A. W. Detrick, New Carlisle, was elected a member of the Clark County Board of Health to fill the unexpired term of the late Dr. M. M. Morrow.

—The annual Diagnostic Chest Clinic was held at Ottawa recently under the supervision of the County Health Department in cooperation with the Putnam County Medical Society.

—Dr. W. H. Hartung, State Director of Health, was the principal speaker at the annual meeting of the Franklin County Public Health Association held at Columbus recently.

—Dr. E. T. Storer, Middletown and Dr. F. C. Anderson, superintendent of the Ohio Tuberculosis Sanatorium at Mt. Vernon, spoke at a meeting of the southwestern district of Ohio Federation of Public Health Officials recently held at Eaton. Dr. James I. Nisbet, Preble County Health Commissioner, is president of the district organization and Miss Mary Ewalt, county health nurse, is secretary. Counties included in the southwestern district are: Butler, Hamilton, Darke, Warren, Montgomery, Miami, Greene and Preble.

—Dr. J. L. Hurst, Dorset, has been appointed health commissioner of Ashtabula County, succeeding the late Dr. W. S. Weiss, Jefferson.

—Dr. Lawrence H. Snyder, professor of medical genetics at the College of Medicine, Ohio State University, recently spoke at the first annual dinner of the Maternal Health Association of Dayton.

—Physicians from Mahoning, Stark and Trumbull County sanitariums aided in examinations at the chest clinic recently conducted at the City Hospital, Salem, under the auspices of the Colum-

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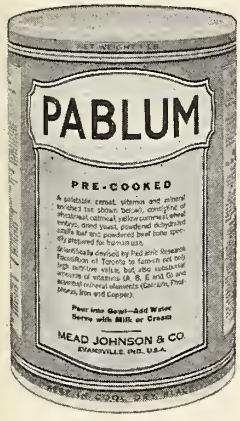
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Iron	0.03	0.0038	0.0008	0.0009	0.00024	0.003
Phosphorus	0.620	0.392	0.125	0.093	0.093	0.180
Copper	0.0013	0.0005	0.00017	0.00034	0.000015	0.00023
Vitamin A	+	— to +	—	— to +	+ + +	+ + +
Vitamin B(B_1)	+ + +	+ +	— to +	+	+ +	+ to + +
Vitamin C	—*	—*	—*	—*	—*	—*
Vitamin D	—**	—**	—**	—**	—**	—**
Vitamin E	+ + +	+ +	—	—	+	+ +
Vitamin G	+ + +	+	—to +	+	+ + +	+ + +
Moisture	7.0	8.0	10.9	35.3	87.0	73.7
Protein	15.0	15.2	11.0	9.2	3.3	13.4
Fat	3.0	7.3	1.4	1.3	4.0	10.5
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biana County Medical Society and operated under direction of the city health department.

—Dr. E. L. Miller of Bowerston has been named president of the Harrison County Board of Health.

—A sight-saving clinic was recently held at the office of the health department at Logan by representatives of the Ohio Commission for the Blind. Dr. Albert D. Frost, Columbus, and Dr. R. A. Howard, Cincinnati, were in charge, with Miss Mary Sears, Columbus, Mrs. Della Griffith, Cincinnati, Dr. W. B. Lacock and Miss Bertha Madlener of the local department aiding them.

—Dr. W. A. McMichael, for many years a physician at Keene, succeeded Dr. S. B. Kistler, Coshocton County Health Commissioner, April 6.

—Dr. Robert P. Bogniard, Ashland, city health commissioner, was elected president of the Ashland County Tuberculosis Association at a recent meeting.

—The annual meeting of the Toledo Council of Social Hygiene was addressed by Dr. Carl A. Wilzbach, executive secretary of the Cincinnati Council of Social Hygiene.

—A bill which would have permitted courts to commit boys having contagious or infectious diseases to the Boys' Industrial School at Lancaster, was recently vetoed by Governor Martin L. Davey.

—The 11th annual meeting of the Ohio Student Health Association was held at the Deshler-Wallick Hotel, Columbus, April 5th.

—Ashland County Medical Society recently submitted a resolution to the Ashland City Council requesting early action on the part of the city administration in securing the services of a competent sanitary engineer to draw up plans for an adequate sewage disposal plant.

—The services of Clermont County Health Commissioner Dr. C. R. Colburn have been discontinued for lack of funds.

— OSMJ —

—Contracts have been let for construction of the tuberculosis sanatorium at Longview Hospital for the Insane. The structure will be 83 feet long and 40 feet wide, two stories high, with a sun roof for patients.

— OSMJ —

—Dr. A. P. Campbell, of Chicago, was guest speaker at a meeting of the staff of St. Joseph's Hospital, Warren. Dr. S. J. Tamarkin, of Youngstown, gave an illustrated talk on "The Gastrointestinal Tract".

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—Oxygen tents, bought from the proceeds of benefit performances at a local theater, have been installed at Fort Hamilton and Mercy hospitals, Hamilton.

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To quote these authors—"the differences in fat retention on these various fats as shown on normal infants are not great; for the normal infant it is probably immaterial whether he absorbs 85% or 95% of his fat intake. It seemed possible, however, that *in subjects who have difficulty in fat assimilation, such as premature infants, the observed small differences might become large differences. A few observations made on premature infants and twins have borne this out*—."

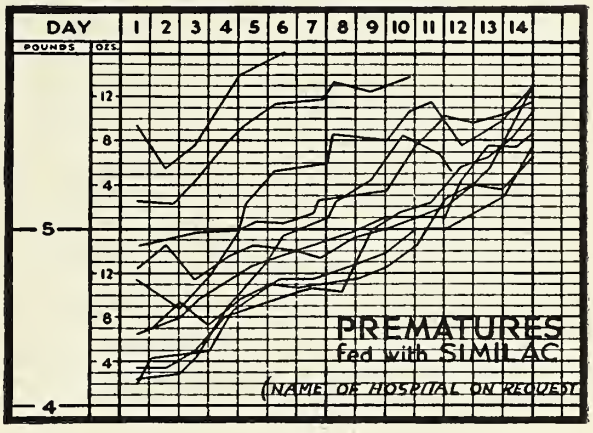
The observations referred to covered only three prematures fed on different fats, but showed an average of 78.4% retention for olive oil as compared to only 52.5% retention for butter fat.

*Holt, Tidwell and Kirk, Studies on Fat Metabolism in Infants—Acta Pediatrica. Vol. XVI, 1933.

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OFFICIAL PROGRAM

89th Annual Meeting

The Ohio State Medical

• • • Association • • •

Wednesday - Thursday - Friday

October 2, 3 and 4

Netherland Plaza

Cincinnati, Ohio

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The Ohio State Medical Journal

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THE CLINICAL PICTURE OF BRIGHT'S DISEASE

By S. D. SIMON, M.D., CINCINNATI, OHIO

THE physician who treats Bright's disease at the bedside is frequently hard-put to establish a definite diagnosis or to offer a conclusive prognosis. The disease as he finds it fails only too often to fall into any of the neat categories provided by the text-books. His perplexity is further increased because he is lead to believe that the application of complex laboratory tests is essential to proper comprehension of the problem. Yet recent studies of Bright's disease, particularly those of Addis and Oliver[1] lead to the conviction that accurate observation and painstaking examination of the urine enable the clinician to cope successfully with the major clinical problems. The aim of this paper is to emphasize the relatively simple procedures upon which this conviction is based. Controversial aspects will be avoided, since simplification is essential to clarity.

Bright's disease is best defined as any bilateral disease of the kidneys in which the urine contains an excessive amount of protein, i. e., albumin, globulin, etc., and an excessive number of casts. This definition would not be valid had not Addis established the normal rates of protein and cast excretion in healthy young adults by the use of a roughly quantitative method. Although his technique cannot ordinarily be applied in general practice, a fairly satisfactory notion of protein, cast, and red cell excretion can be gained by examining the morning urine obtained after a 12 to 15 hour abstention from fluids. This is conveniently accomplished as a part of the concentration test. By this means the clinician obtains insight into the extent of the renal lesion as well as into its type.

Since the urine alone contains the direct evidence of renal damage, the physician himself must examine it. As Addis has very forcibly stated, the clinician has relegated to the laboratory technician the one examination which sheds direct light upon the nature of the renal disease. Urine obtained at random does not suffice. Specimens must be as highly concentrated as possible and of an acid reaction, since hyaline casts disappear rapidly from a dilute or alkaline urine. Red blood cells must be identified not only when typical, but likewise in all their bizarre shapes; a technician is apt to overlook the latter. Red cell casts must be recognized even when they are present only as yellow coarsely granular cylinders of atypical configuration. A particular kind of cast, designated by Addis as the "renal failure" cast must be sought for diligently; these are short, dark, abnormally broad structures with squared-off ends. They occur only in uremia, and have therefore a unique and portentous significance.

Examination of the urine reveals to the clinician something more than the amount of protein and the number and kind of formed elements. Simple concentration and dilution tests, based as they are upon the knowledge that renal function can be roughly measured by forced fluctuations of urinary specific gravity, enable the clinician to estimate the degree of renal impairment. As renal function diminishes, urinary specific gravity fluctuates within narrower and narrower limits, finally becoming practically fixed around the figure 1.01. While not as delicate or reliable as

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the blood urea clearance test of Van Slyke[2], concentration and dilution tests have the distinct advantage of practicability, and probably yield more reliable information than the widely used phenolsulphonphthalein test.

It would be folly, however, to maintain that the entire picture of Bright's disease is reflected in the urine. One of the most significant developments of recent years is the conviction that many and possibly most of the signs and symptoms of Bright's disease are extra-renal in origin and nature. Edema, hypertension, dyspnea, and anemia, for example, are frequently induced by changes not directly referable to the kidneys. In other words, the renal lesion is merely a single part of various clinical syndromes known as Bright's disease; the clinician who fails to recognize this fundamental fact cannot hope to treat his patients adequately or intelligently.

Once the diagnosis of Bright's disease is established, there arises the problem of identifying its particular variety. Classification, although sometimes odious, is an inescapable necessity, since treatment and prognosis depend upon this further identification. Since Addis and Oliver have based their classification in large part on the results of urine analysis, it is readily applied in actual practice. According to them, there are three general classes of Bright's disease: hemorrhagic, degenerative, and arteriosclerotic. These correspond quite closely to the glomerulonephritis, nephrosis, and nephrosclerosis of Volhard and Fahr, but do not recognize Volhard's[3] further division of glomerulonephritis into a focal and diffuse type, or nephrosclerosis into a benign and a malignant form.

Hemorrhagic Bright's disease is characterized throughout its entire course by one, and only one, never-failing sign: the constant presence in the urine of an excessive number of red blood cells. The outstanding renal lesion is glomerulitis, although the renal changes are by no means confined to the glomeruli. The acute or initial stage is marked by gross hematuria, moderate hypertension, a tendency to suppression of urine, and a hard edema. Prognosis in the early stage is extremely difficult, for the severity of the initial manifestations bears no relation to the eventual outcome. Following the initial attack, the disease may subside with complete healing, which is frequent, may lapse into a latent stage, may become chronic, or may progress rapidly and stormily to uremia and death; the last-named course is properly designated as sub-acute (Volhard). Improvement to the latent stage, which may eventuate in complete recovery or relapse into the chronic active stage, is marked by the complete disappearance of all evidences of the disease except slight hematuria; this alone points backward to the original hemorrhagic process. It is at this stage, as pointed out by McCann[4], that the disease may be lightly dismissed as "essential hematuria". The persistence of hematuria, proteinuria, and impaired renal function beyond a period of several months indicates chronicity, with the strong probability of uremia and death within a few years. In the chronic stage, when hematuria is minimal, and edema and proteinura are maximal, an erroneous diagnosis of lipoid nephrosis is frequently made. It is here that the history or demonstration of hematuria is of particular significance in diagnosis and prognosis. The terminal stage is often ushered in by a marked diminution of edema and proteinuria, and is characterized by fixation of urinary specific gravity, appearance of renal failure casts, and increased non-protein nitrogen of the blood. In other words, the nephrotic syndrome is replaced by the uremic syndrome. When hemorrhagic Bright's disease reaches this stage the end is imminent.

Degenerative Bright's disease is characterized clinically by excessive proteinuria and massive edema. The corresponding renal lesion is tubular degeneration. The etiological factors are numerous and diverse, for the term degenerative Bright's disease includes so heterogeneous a group of renal affections as mercury poisoning, amyloid disease, lipoid nephrosis, and the kidney of pregnancy. Although strikingly dissimilar in origin, these renal syndromes nevertheless have one very important feature in common: the renal lesions are reversible, so that complete healing is possible at any time. In this they differ radically from the nephrotic syndrome of hemorrhagic Bright's disease, in which recovery is extremely rare. The urine, which ordinarily is of normal specific gravity, contains a great deal of protein and large numbers of degenerated epithelial cells and casts; erythrocytes are absent. In chronic nephrosis the pronounced proteinuria leads eventually to diminished plasma proteins; this lowers the osmotic (or oncotic) pressure of the plasma, and when a certain critical level is reached, edema occurs. Hypertension, retinal changes, and cardiac enlargement are nearly always lacking. When the etiologic factor can be removed, degenerative Bright's disease can be cured; even in the cryptic forms spontaneous recovery is fairly common. Only too frequently, however, the patient succumbs to some intercurrent infection such as pneumococcus peritonitis. Death is very rarely due to true renal insufficiency.

Arteriosclerotic Bright's disease is characterized by the onset of a renal syndrome following prolonged hypertension. The renal lesion is in essence a vascular one, diminished renal function being apparently due to diminished renal blood flow (Van Slyke). In the milder forms, generally associated with moderate hypertension and

arteriosclerosis, renal insufficiency does not occur; death is due most frequently to cardiac failure or cerebral hemorrhage. In the so-called malignant form, renal insufficiency intervenes relatively early in life and dominates the clinical picture throughout. It is accompanied by cardiac enlargement, cardiac insufficiency, and hypertensive retinopathy. Proteinuria is not marked unless congestive heart failure has occurred. The urinary sediment shows only a moderate number of casts, principally of the hyaline variety. Erythrocytes are generally within normal limits, but occasionally may be sufficiently numerous to cause confusion with hemorrhagic Bright's disease. In such instances, only the history of an initial hemorrhagic syndrome can distinguish with certainty between them. The renal lesion of arteriosclerotic Bright's disease is apparently irreversible; sooner or later, urinary specific gravity becomes fixed, blood non-protein nitrogen increases, renal failure casts occur, and death in uremia follows.

Treatment of Bright's disease depends upon accuracy in diagnosis and skill in the interpretation of symptoms. In the initial or acute stage of the hemorrhagic form, suppression of urine must be overcome, the effects of edema counteracted, and acute cardiac failure prevented. Water bound by the tissues and held in the tissue spaces is released by sharp limitation of fluids and radical restriction of salt intake. In reducing salt intake it must be remembered that the sodium ion rather than the chloride ion is implicated in the formation of edema. Repeated spinal puncture and the intravenous administration of glucose will frequently control the cerebral manifestations. Digitalis is of value in preventing cardiac failure. Diuretics are to be avoided. In the chronic stage with marked edema, plasma proteins are restored to a normal level by a high calorie, high protein diet; restriction of proteins is decidedly harmful, since the proteins lost in the urine must be replaced. Salt intake must be minimal. In the terminal stage the patient's comfort is of paramount importance, since little else can be accomplished.

In degenerative Bright's disease, treatment is directed initially toward the etiological factors where these are obvious or ascertainable. In the cryptic forms, such as lipoid nephrosis, the treatment is essentially the same as in the nephrotic type of hemorrhagic Bright's disease. Chronic focal infections should be sought for and eliminated. Thyroid administration is sometimes of value. Salyrgan should be tried in conjunction with acid-producing salts such as ammonium chloride and ammonium nitrate. Urea by mouth is sometimes successful when other diuretics fail.

Therapy of mild arteriosclerotic Bright's disease deals primarily with the underlying arteriosclerosis and its sequelae. In the early stages of the malignant type, treatment is dictated by the hypertension and its resultant cardiac involvement. As the disease progresses and the inevitable renal insufficiency sets in, therapy is mainly supportive. Radical protein restriction does more harm than good, frequently contributing to the cachexia to which these patients are invariably subject. The importunities of this stage of Bright's disease tax even the most skillful of physicians to the limit of his abilities.

SUMMARY

A careful history, accurate bed-side examination, and thorough analysis of the urine will frequently reveal to the conscientious clinician the nature of the renal lesion involved in Bright's disease. A given case will be found to conform to one of three general classes: hemorrhagic, degenerative, or arteriosclerotic. Insight into prognosis is gained by serial examinations of the urine and by a knowledge of the probabilities inherent in each type of the disease. Treatment is dictated by etiologic factors when these are apparent, but in general depends upon the presenting signs and symptoms. Successful therapy must deal extensively with the extra-renal manifestations, since the renal lesions can rarely be directly influenced. And finally, there is no short-cut by which the physician can attain clarity and precision in his point of view; it is imperative for him to deal directly and painstakingly with the disease in all its manifestations.

19 GARFIELD PLACE.

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—OSMJ—

Interstate Post-Graduate Assembly

The International Assembly of the Inter-State Postgraduate Medical Association of North America will be held in the Masonic Temple, Detroit, Michigan, October 14-18, 1935, with pre-assembly clinics on Saturday, October 12, and post-assembly clinics Saturday, October 19, in the Detroit hospitals.

The program has been arranged by a committee of which Dr. George Crile, Cleveland, is chairman.

Ohio physicians who will appear on the program are: Dr. William E. Lower, Dr. William J. Gardner, Dr. Louis J. Karnosh, Dr. Wallace S. Duncan, Dr. Russell L. Haden, Dr. George Crile, and Dr. T. Wingate Todd, all of Cleveland.

TRAUMATIC SUBDURAL HEMATOMA; A REPORT OF TWENTY-TWO CASES

By W. JAMES GARDNER, M. D., CLEVELAND, OHIO

SUBDURAL hematoma is a very interesting sequel of cranial trauma which is being recognized with increasing frequency. The lesion consists of an encysted, partially liquefied blood clot situated over the convexity of one or both cerebral hemispheres between the dura and arachnoid membranes. The accident responsible for this lesion is a minor one, as a rule, and the force of the blow usually is exerted in an anteroposterior direction. The resulting dislocation of the brain within the cranial cavity stretches and tears one or more of the short cerebral veins communicating with the immobile sagittal sinus. There occurs at once a large extravasation of blood over the convexity of the hemisphere in the subdural space. The bleeding ceases when the intracranial pressure reaches a level at which no more blood can leave the torn vein. This degree of intracranial pressure is not incompatible with life and the immediate symptoms may be mild and transient.

The subsequent behavior of the subdural clot is unique. The usual regressive changes and absorption do not occur with a clot in this location. Within a few days or a week the clot is surrounded by a mesothelial-like membrane after which the contents liquefy, forming a hemorrhagic cyst. During this stage symptoms may be absent or trivial. The contents of the cyst, however, undergo a slow progressive augmentation[1] due to the accession of cerebrospinal fluid which is drawn through the semipermeable lining by the osmotic tension of the contained blood proteins. Zollinger and Gross[2] recently have advanced evidence to indicate that disintegration of the encysted blood over a period of months produces a great rise in its effective osmotic pressure. Accompanying this increase in size of the cyst, symptoms of increasing intracranial pressure supervene and most of these patients probably die without the true nature of the condition having been recognized. (Figure 1).

Since these changes do not occur with clots in other cavities, they must be due to the environmental conditions present in the subdural space. This space has recently received the attention of Leary and Edwards[3] who present evidence to prove "(1) that the subdural space does not correspond to the serous spaces; (2) that the dura is not lined by mesothelium (as previously supposed), but by fibroblastic tissue; (3) that the arachnoid is covered by cells which do not appear to be mesothelial, which are probably of ectodermal origin and to which the arachnoid apparently owes its impermeability". This space, therefore, is unique anatomically and is provided with no adequate means of getting rid of debris. These considerations undoubtedly provide the explanation for the singular behavior of the subdural hematoma.

Read before the Section on Nervous and Mental Diseases, Ohio State Medical Association, at the 88th Annual Meeting, Columbus, October 4-6, 1934.

CHARACTER OF THE LESION

The gross as well as the microscopic characteristics of these lesions are of interest. Grossly, the outer wall of the hemorrhagic cyst, which is next to the dura, is a great deal thicker than the inner wall, which is next to the arachnoid. The outer wall is adherent to, but strips easily from, the inner surface of the dura, leaving relatively few bleeding points. As a rule, the inner wall is not at all adherent to the arachnoid and is avascular except at its margins. The contents of the cysts vary from a thin yellow or brown fluid to a thicker, very dark red liquid and they usually contain shaggy remnants of degenerating clot.

The microscopic appearance of the neomembrane surrounding the degenerating clot has been well described by many authors, notably by Putnam and Cushing[4] in 1925. Briefly, the outer wall may be said to resemble a highly vascular layer of granulation tissue of varying thickness, slightly adherent to the inner surface of the dura. These observers were particularly impressed with the frequent occurrence of a layer of large irregular "mesothelial-lined blood spaces" in the neomembrane just below the line of demarcation between the dura and the membrane. The inner wall of the cyst is much thinner, and consists of a layer of fibrous tissue, a few cells in thickness, with a single layer of cells resembling mesothelium on the surface next to the arachnoid. This portion of the membrane contains no blood vessels except at its margins.

CLINICAL STUDY

In the files of the Cleveland Clinic there are twenty-two typical cases of subdural hematoma. Eighteen of these have been observed within the past four years and represent almost 5 per cent of all expanding intracranial lesions. A summation of our experiences with these lesions produces the following composite picture.

A man, aged fifty years, slips on the ice and falls, striking the occiput. He gets to his feet, slightly dazed for a minute, following which he has pain in the head for a few hours, but this is not severe enough to warrant his going to bed. Thereafter, he feels quite well and dismisses the accident from his mind. Four weeks later he

begins to have headache, which increases in severity. The relatives then notice changes in his behavior, accompanied by mental confusion and increasing somnolence. These signs and symptoms show gradual progression and finally the patient is admitted to the hospital three months after the accident in a stuporous condition.

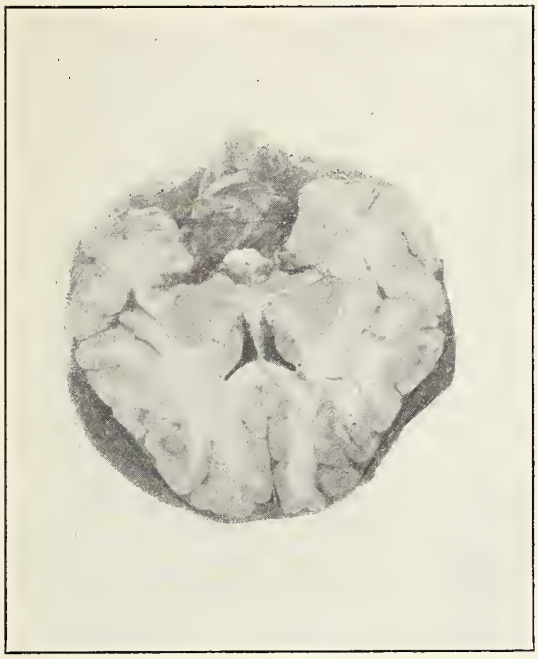


Fig. 1. Autopsy specimen (Case 6). Bilateral subdural hematoma. This specimen, fixed before removal, illustrates well the compression of the underlying brain. The fluid content of the lesion has escaped leaving only the cyst walls and solid clot.



Fig. 2. The lesion exposed by craniotomy. The dura is being reflected from the outer wall of the hematoma (Case 9).



Fig. 3. The outer wall has been incised permitting the escape of the fluid content (Case 9).

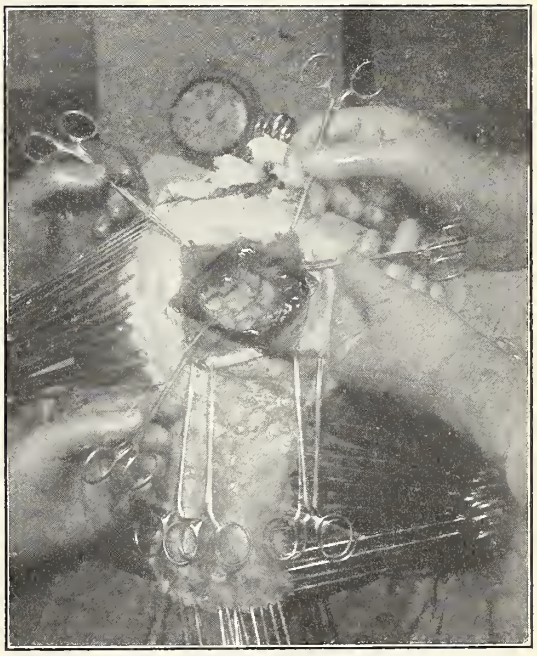


Fig. 4. An incision through the inner wall discloses the compressed but otherwise normal brain beneath (Case 9).

On examination, the patient is aroused with difficulty. He is dehydrated. The neurologic signs are vague and conflicting. There is no choking of the optic discs. The spinal fluid pressure is normal and the fluid is slightly yellow. Roentgenograms of the skull yield entirely normal findings. The patient's stupor deepens and his temperature begins to rise.

He is taken to the operating room where tre-

TABLE 1

Clinical Study of Twenty-Two Cases of Subdural Hematoma

No.	Date of Operation (or autopsy)	Age	Sex	Nature of Trauma	Site	Length of Time Unconscious	Position of Pt. Following Trauma	Time—Trauma to Operation	Latent Interva
1	5–3–26	59	M	Fell on ice	Occiput	2 minutes	Erect	11 weeks	3 weeks
2	7–13–28	11	M	Fell on street	Left forehead	0	Erect ?	8 weeks	3 days
3	1–20–29	48	M	Struck hy auto	Right side	2 minutes	?	18 weeks	7 weeks
4	2–10–30	52	M	Collision	Left forehead	1½ hours	Erect	9 weeks	7 weeks
5	1–14–31	6	M	Struck hy auto	Left side	22 days ?	Lying	15 weeks	none
6	5–14–31	51	M	Traumatic epilepsy for 25 years. No recent injury ?	?	?	?	?	?
7	6–2–31	55	M	Struck hy auto	Right side	0	?	11 weeks	4 weeks
8	9–3–31	40	M	Auto collision	Forehead	0	Erect	33 weeks	6 weeks
9	3–11–32	47	M	Fell on ice	Occiput	Few minutes	Erect	9 weeks	?
10	5–6–32	50	M	Fell on steps	Occiput ?	?	?	7 weeks	6 weeks
11	11–2–32	14	M	Struck hy pitched horseshoe	Vertex	0	Erect	14 weeks	none ?
12	11–14–32	62	M	Tripped and fell to floor	Forehead	0	Erect	13 weeks	4 weeks
13	12–5–32	41	M	"Rahhit" hlow	Occiput	0	Erect	15 weeks	none ?
14	12–20–32	64	F	Struck head on heam	Vertex	0	Erect	7 weeks	3 weeks
15	2–10–33	19	M	Boxing	Forehead	0	Erect	15 weeks	4 weeks
16	3–8–33	54	M	Kicked hy horse	Right forehead	0	Erect	8 weeks	1 week
17	10–7–33	25	M	Struck hy rowhoat while in the water	Left side	0	Erect	5 weeks	none
18	1–27–34	30	M	Fell from moving auto	Occiput	0	Erect	7 weeks	3 weeks
19	3–24–34	36	M	Fell on ice	Occiput	0	Erect	5 weeks	4 weeks
20	6–4–34	56	M	Auto collision No head injury ?	Forehead ?	0	Erect	22 weeks	13 weeks
21	7–16–34	62	F	Struck head on cupboard	?	0	?	?	?
22	9–19–34	45	M	Auto collision	Forehead	1½ hours	Lying	9 weeks	2 weeks

phine openings are made on each side of the skull at a point midway between the ear and the vertex. The dura is opened on one side and a normal brain cortex is exposed. Through the perforation on the other side the dura appears bluish. As it is incised the dark outer wall of a hematoma is exposed. (Figures 2, 3 and 4). When this is opened there is a spurt of dark coffee-colored fluid. Additional fluid is removed by aspiration and then the brain can be seen. The brain is depressed 3 cm. from the dura and appears yellow as viewed through the intact inner wall of the hematoma. By irrigation with warm saline some fragments of degenerated clot are washed out and the brain gradually begins to pulsate and expand until it approaches the dura. The patient arouses from his stupor and begins to struggle as the incision is closed about a rubber tissue drain.

The patient's condition is greatly improved for a day or two but by the third day his stupor has returned and is accompanied by contralateral hemiparesis. The surgeon is worried over the pos-

TABLE 1

Clinical Study of Twenty-Two Cases of Subdural Hematoma

Duration of Symptoms	Nature of Symptoms	Signs	Fundi	Cerebrospinal Fluid Pressure	Xantho.	Cells	Operation	Location	Result
8 weeks	Headache, somnolence, blurring vision, vomiting	Stupor, paresis of legs, hilateral Babinski	Neg.	120	0	0	Autopsy	Right	Died
8 weeks	Headache, vomiting, diplopia, somnolence	Bilateral 6th nerve paralysis. Left lower facial paralysis, awkward left hand	4 D.	not done			Craniotomy	Right	Recovered
11 weeks	Headache, failing vision, confusion, stupor	Right hemiparesis	3 D.	not done			Craniotomy	Left	Recovered
1 week	Amnesia, stupor	Left pupil dilated, right lower facial paralysis	Slightly hazy	400	0	3	Bilateral suhtemporal decompression	Right	Recovered
15 weeks	Aphasia, personality changes	Left Babinski, aphasia	Neg.	Normal	0	0	Craniotomy	Left	Recovered
9 weeks	Headache, somnolence, stupor	Stupor	Neg.	130	+	1	Autopsy	Bilateral	Died
6 weeks	Headache, confusion	Aphasia, right hemiparesis	Mild edema	140	+	1	Craniotomy	Left	Recovered
27 weeks	Headache, somnolence	Oppenheim right	Neg.	Suhatmo-spheric	+	12	Craniotomy	Left	Recovered
9 weeks ?	Headache, personality changes, somnolence	Left Babinski	Neg.	270	+	2	Right craniotomy, left trephine	Right	Recovered
1 week	Headache, stupor	Stupor, left abdominal reflex absent	Neg.	150	+	0	Bilateral trephine	Left	Recovered
14 weeks	Headache, vomiting	Nystagmus	1 D.	400	0	2	Left craniotomy, right trephine	Left	Recovered
9 weeks	Headache, dizziness confusion	Right lower facial paralysis, right Babinski	Neg.	240	+	0	Right craniotomy	Right	Recovered
16 weeks	Headache	None	Hazy	160	+	43 (fresh blood)	Right trephine	Right	Recovered
4 weeks	Headache, confusion	Right pupil dilated, stupor	Neg.	170	+	23	Bilateral trephine	Right	Recovered
11 weeks	Headache, vomiting, vertigo, impaired memory	Left homonymous defect	Hazy	230	0	4	Craniotomy	Left	Recovered
7 weeks	Headache, confusion, left hemiplegia	Mild left hemiparesis	Mild edema	75	+	1	Craniotomy	Right	Recovered
5 weeks	Headache, vomiting, confusion	Left hemiparesis, left hypaesthesia	Neg.	30	0	?	Right trephine	Right	Recovered
4 weeks	Headache, vomiting	Right abdominal reflex sluggish, left Babinski	Neg.	210	0	0	Bilateral trephine	Right	Recovered
5 days	Headache, somnolence, confusion	Pulse 44	Neg.	350	+	0	Bilateral trephine	Bilateral	Died
9 weeks	Headache, coma	Coma	Slightly hazy	75	+	1	Bilateral trephine	Bilateral	Recovered
?	Headache, unsteadiness, coma	Coma	Neg.	120	+	?	Bilateral trephine	Bilateral	Died
7 weeks	Vomiting, left hemiplegia, somnolence	Left hemiparesis, right hemianopsia, somnolence	Early choking	240	+	0	Right craniotomy, left trephine	Right	Recovered

sibility of a postoperative hemorrhage but from previous experiences he believes that the condition is caused by reactionary cerebral edema. With supportive measures the patient improves, is out of bed on the tenth day, and is able to return to his home on the fourteenth day and to go back to work in three or four months.

The sex and age incidence in this small series of cases affords interesting speculation. Only two of the twenty-two patients were women. This perhaps represents the comparative incidence of cranial trauma in the two sexes. However, two-thirds of the patients were more than forty years of age. Certainly two-thirds of the instances of cranial trauma do not occur in patients past forty. The preponderance of these lesions in older patients must be explained by the lessened elasticity and greater fragility of the cerebral veins which develop with advancing age.

Contrary to the prevailing opinion, chronic alcoholism was not a predisposing factor in this series. It was specifically denied in fifteen cases. In seven cases the question was not asked. One patient was intoxicated at the time of the accident.

The reason why these lesions usually follow a mild cranial trauma offers another interesting field for speculation. In only six cases in this series was the blow to the head of sufficient force to cause unconsciousness. In no case was there roentgenographic evidence of a fracture of the skull. In some cases the trauma was so mild as to be completely forgotten by the patient and relatives and only could be brought to mind by persistent questioning. It is inconceivable that a tear of the cerebral veins is more common after a mild trauma than after a severe one. In looking for an explanation of the frequency following a mild injury one should not lose sight of the fact that after a mild cranial trauma, the patient's instinct prompts him to get on his feet whereas the victim of a severe blow is unconscious and therefore usually prone. In two-thirds of the cases in this series the patient either maintained or assumed the erect posture immediately after the accident and in only two cases were they definitely known to lie down. I can advance no reason why the erect posture following cranial trauma should favor venous bleeding, unless it could be because of a lowering of arterial and rise in the venous pressures secondary to partial syncope. On the other hand, in cases of severe cranial trauma the maintenance of the horizontal position, the occurrence of cerebral edema, the laceration of the membranes and the presence of a fracture seem to militate against the formation of a large subdural clot or if one has formed, one or more of these conditions may predispose to its absorption.

An analysis of the twenty-two cases (Tables 1 and 2) herein reported indicates that the lesions occur more frequently in men; the ratio of men to women was twenty to two. Two-thirds of the patients were past forty years of age and the lesion was most frequent in the fifth decade. The force of the blow was exerted in an antero-posterior direction, that is, it was received on the frontal or occipital regions in fifteen cases, on the side of the head in three cases, on the vertex in two cases, and in two cases the site was not known. That the blow was usually a mild one is attested by the fact that only six of the patients were rendered unconscious and only three of these for more than a few minutes.

The average time interval between the trauma and operation (or necropsy) was twelve and a half weeks. The shortest interval was five weeks and the longest was thirty-three weeks. When the interval is much longer than this, it would appear likely that the implicated trauma is not the responsible one. For instance, in Case 6 the only history of injury to the head occurred twenty-five years before at which time the patient was thrown from a buggy by a runaway horse and alighted on his head. Following this, he suffered from post-traumatic epilepsy. The pressure symptoms in this case were of only nine weeks' duration and from the gross and microscopic appearance of the hematoma, it is inconceivable that

TABLE 2

SUMMARY OF FINDINGS IN TWENTY-TWO CASES OF SUBDURAL HEMATOMA

Average age	44.1
Sex	
Male	20
Female	2
Nature of trauma	
Fall	6
Auto	8
Miscellaneous	7
Unknown	1
Site of trauma	
Frontal	8
Occipital	7
Side	3
Vertex	2
Unknown	2
Unconsciousness immediately after injury	6
Average time	
Trauma to operation	12.5 weeks
Latent interval	3.6 weeks
Duration of symptoms	8.6 weeks
Nature of symptoms	
Headache	19
Changes in intellectual sphere	19
Vomiting	7
Dizziness	3
Visual disturbance	3
Neurologic signs	
True localizing	8
No localizing	5
False localizing	5
True and false localizing	4
Optic discs	
Choking	6
Hazy	4
Negative	12
Cerebrospinal fluid	
Pressure	
Normal	10
Increased	8
Subnormal	2
Color	
Xanthochromic	13
Colorless	7
Operation	
Trephine	8
Craniotomy	12
Autopsy	2
Location	
Bilateral	4
Right	11
Left	7
Result	
Recovered	18
Died	4

the lesion was twenty-five years old. The latent interval during which symptoms were mild or absent averaged 3.6 weeks and the period of definite symptoms 8.6 weeks.

Headache was the chief complaint in nineteen cases. Alterations in the intellectual sphere as shown by confusion, somnolence and personality changes also were present in nineteen cases. Somnolence, when present, was out of all proportion to the degree of intracranial pressure. The most stuporous patients frequently had a normal or subnormal spinal fluid pressure. This disproportion between the symptoms of pressure and the actual pressure as measured by spinal puncture is so frequently present as to constitute an important diagnostic sign. Vomiting occurred in seven cases, vertigo and visual complaints each in three instances. Convulsions did not constitute a symptom in any case with the possible exception of Case 6.

The neurologic findings indicated the side of the lesion in eight cases. In five there were no localizing signs. In five the neurologic signs pointed to the wrong side of the head and in four patients with unilateral lesions the neurologic signs indicated bilateral damage. Two patients exhibited a homolateral homonymous field defect. This extremely rare finding must be associated in some way with the marked dislocation of the brain occasioned by these large lesions. It could be explained by pressure on the optic radiations in the region of the lateral geniculate by the margin of the incisura of the tentorium. In the four cases in which there were hematomas on both sides, no localizing signs were present.

A definite choking of the optic discs was present in three cases, a mild edema in three cases, a haziness of the disc margins in four cases and in twelve instances the discs were normal. Spinal puncture in twenty cases revealed a normal or subnormal pressure in twelve instances and an increased pressure in eight. In thirteen cases the spinal fluid was xanthochromic and in seven it was colorless.

Twelve patients were treated by formal craniotomy and all twelve recovered. In eight cases the operation consisted of a simple drainage of the lesion through a cranial perforation 1½ cm. in diameter. Two of these patients died. In my opinion the type of operation was not responsible for these deaths. In both instances there were bilateral lesions. One patient (Case 21) was moribund when the operation was performed. The other (Case 19) did not regain consciousness and died eighteen hours after operation. Autopsy revealed a large recent pontine hemorrhage. Neither of these patients could have been saved by the decompression afforded by a formal craniotomy. The other six patients treated by simple drainage recovered as quickly and completely as those treated by craniotomy and complete evacuation. In none of these cases was an attempt made to remove any part of the wall except that immediately beneath the craniotomy opening. Since drainage through a single opening has proved satisfactory, through and through drainage by means of two openings as advocated by Fleming and Jones[5] was not employed in any of these cases.

Of the eighteen patients in this series who recovered, fourteen were restored practically or entirely to their former state of health. One patient (Case 4) has a mild extra-ocular muscle imbalance which will not permit him to return to his former occupation as an accountant. One patient (Case 9) has been completely disabled by the development of a communicating hydrocephalus. Another (Case 5) shows personality changes from the same cause. Patient number 17 has had two grand mal seizures in the twelve months that have elapsed since operation. In the twenty cases in which operation was performed, there were 90 per cent recoveries and 70 per cent cures. These figures indicate that when recognized and properly treated the subdural hematoma represents the most benign of all expanding intracranial lesions.

(Another communication regarding the chemistry and cytology of the contents of subdural hematomas is in the process of preparation).

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—OSMJ—

Survey of Chronic Illnesses

President Roosevelt recently allotted $3,450,000 of work relief funds to the U. S. Public Health Service for a survey of chronic diseases. It is estimated that this survey will provide a year's employment for 3,500 persons. Surgeon General Hugh S. Cumming has stated that the project will include a house-to-house canvass in selected urban and rural communities to determine the prevalence of long-standing illnesses among the rich, poor and middle-class families; physical examinations in a small number of instances to check the accuracy of the canvass reports; and a survey of medical facilities for chronic diseases. Ohio's share of the proposed expenditure is $338,000.

DERMATOSES INVOLVING THE EYELIDS *

By HOWARD J. PARKHURST, M.D., Toledo, Ohio

THERE are about fifty skin conditions in which the eyelids may be involved. Since many of them are rare, their consideration in this brief paper would only be confusing. Involvement of the eye in leprosy is of no practical importance to us in Ohio. While the peculiar angioid streaks of the retina which accompany pseudoxanthoma elasticum are of great interest, the extreme rarity of this disease places it outside the scope of the present paper. Let us, therefore, consider only those conditions which may be encountered in our daily practice.

In severe cases of ivy poisoning we usually find the eyelids markedly involved, with edema, erythema and vesiculation. The delicate skin of the eyelid is especially susceptible to external irritation, and its laxity permits a great deal of swelling. This severe inflammatory reaction, with its attendant discomfort, can probably best be relieved by the local application of saturated boric acid compresses. The affected parts should first be washed with a mild soap and water in order to remove the causative irritant. And right here I should like to say what I think of soap and water. I know that there are many who feel that soap and water should not be used on an inflamed skin. But I feel that its cleansing value is second to none, and I very seldom encounter a case of any kind in which it cannot be used, and used with great benefit. Of course, a mild soap, such as plain castile or Ivory, should be employed, and the water must not be too warm. Plenty of soapless water must be used for rinsing, in order to remove all traces of soap and soapy water from the surface. Rough wash clothes must not be used, and the skin must finally be dried by patting, not by rubbing.

Plants of the primrose family also may irritate the skin, including the eyelids, of the many individuals who are susceptible, though not so severely as does poison ivy. Japanese lacquer is a primrose derivative, and during the period when the game of Mah Jongg was popular, many a player's eyelid was irritated by the lacquer on the sets. Among the less common plant irritants is pampas grass, which is often sold by florists. I recall the case of a florist thus irritated, whose eyelids were involved as a part of the facial eruption. Many persons are sensitized to orris root, which is a common ingredient of face powders and so-called dry shampoos. I can recall cases in which eyelids were markedly inflamed after the use of these dry shampoos. Other individuals are susceptible to pyrethrum, which is a common ingredient of sprays for the destruction of insects.

The eyelids are especially exposed to contact with sprays and dusts in the air. I recall the case of a passenger car inspector, whose eyelids were severely irritated by dust in the cars. The exact irritant could not be determined. A spray painter, handling lacquer, developed a persistent inflammation of the eyelids and front of the neck, which forced him to abandon his occupation. Glass workers come in contact with lime dust, and many are irritated by it. A year ago I saw a man whose face and lower eyelids were much inflamed due to contact with a certain shaving cream, which fortunately is not among the popular brands. In 1928 Oliver[1], of Chicago, described a number of cases of recurrent dermatitis, in which the eyelids also were involved, due to susceptibility to *para red*, a compound used in printed colored rotogravure sections of certain Sunday newspapers. These eruptions subsided during the week, and flared up on Sunday night or Monday. I have encountered none in Toledo.

Paraphenylendiamin is a too common ingredient of fur dyes and hair dyes, and occasionally one encounters susceptible persons whose eyelids and necks are considerably inflamed from this source. An identical or similar aniline dye is found in "Lash-Lure" and in "Godefroy French Hair Coloring", which, when applied to the eyelashes of one who is susceptible, may cause dermato-conjunctivitis and even ulceration and necrosis of the cornea. Several such tragic cases have been reported in the *Journal A.M.A.* during the past 16 months, and the last case report, by Forbes and Blake[2] of Tampa, includes a bibliography. In 1931 Cummer[3] of Cleveland, described a case of dermitis of the eyelids due to dionin (ethylmorphine hydrochloride), in which local hypersensitiveness had developed after 11 years' use of the product. I have also seen such a case.

Hollander[4] of Pittsburgh, in 1931 described a dermatitis of a woman's eyelids caused by contact with Wildroot Hair Tonic, which her husband had been using. The tonic from his hair was deposited on the bed-pillow, and thus came in contact with the wife's eyelids as she slept. Ointments containing chrysarobin may not be used on the head or face, since they irritate the eyes, and preparations containing much sulphur, salicylic acid, ammoniated mercury or tar, must be handled with extreme caution. Patients using such preparations for the treatment of skin diseases should be told to wash their hands immediately after making the application, so that a careless gesture

*Read before the Eye, Ear, Nose and Throat Section of the Toledo Academy of Medicine, November 30, 1934.

of the finger may not convey the irritant to the eyelid.

As a result of repeated external irritation, scratching and rubbing, a chronic eczema of the eyelids may arise. I have often observed this condition in so-called allergic cases, the skin of the eyelids being red to brown, more or less thickened, and either moist and weeping or dry, fissured and scaling, usually with marked discomfort. The offending agents may be single, but are more often multiple, and Doctor Figley and I[5] saw several such cases in which the inhalation of minute quantities of silk dust seemed to be the chief etiologic factor. While the cause is being sought, the patient's comfort must be promoted by the local application of bland protective ointments, zinc oxid ointment being employed if there is a tendency to moisture, and boric or mild yellow mercury oxid ointment if the eyelid is too dry. The skin should first be cleansed briefly with soap and water, to remove possible external irritants, and patted dry, and the ointment should then be applied sparingly and rubbed in very gently with the fingertips; after this the excess is gently wiped off with cotton and a very little plain talcum is dusted over the surface so that it feels cool and comfortable.

In practically all cases of eczema there is more or less of a seborrheic element. As is well known, seborrhea remains latent on the scalp for years, and at times may flare up and extend to the ears, eyebrows, upper eyelids and nares, the skin in these locations becoming brownish red, often rather greasy, and slightly crusted or faintly scaling. This eruption itches, and if the patient rubs or scratches the affected areas become eczematized. Conversely, eczema or any severe dermatitis may precipitate a secondary seborrheic outbreak as a complication. So far as the end-result on the eyelids is concerned, the difference is about the same as that between tweedle-dum and tweedle-dee. Suffice it to say, in all cases of eczema involving the face and eyelids the scalp must receive immediate antiseborrheic treatment, such as very frequent shampooing with tar soap and if necessary, suitable lotions or ointments. Only in this manner can the eczema be effectively treated. The patient also must not scratch or rub the affected parts. If the scalp does not receive constant attention, recurrences of the seborrhea are the rule.

Rosacea, commonly called acne rosacea, affects the nose or other parts of the mid-face in seborrheic individuals, and in a few cases of rosacea blepharitis, probably seborrheic, as well as conjunctivitis and keratitis, may occur. To quote an abstract[6] in the Archives of Dermatology of an article by Cranston Low of Edinburgh: "The conjunctivitis may be of two types, the first a non-characteristic form, with slight redness of the mucous membrane. The palpebral conjunctivae are chiefly affected here, and the picture is due to the presence of numerous dilated capillaries. The second type is less common but more severe, appearing as a number of small raised papular lesions, pinhead-sized, grayish, and surrounded by a ring of minute dilated capillaries. The lesions usually occur on the bulbar conjunctivae. The lesions resemble closely those of phlyctenular conjunctivitis. These two types of conjunctival lesions usually occur together, and in most cases a scaly blepharitis is also present. The keratitis occurs in rosacea in three forms: a mild form with ulceration of the cornea with surrounding infiltration; a severe form with ulceration and subepithelial infiltration, and the severest form of all, with a progressive inflammation of the cornea resembling rodent ulcer. Low thinks that the skin and eye lesions are etiologically identical. The incidence of eye lesions does not depend on the severity of the rosacea, as most cases with eye lesions seem to show the milder type of rosacea. A 1 per cent ichthyol-zinc ointment or a 1 per cent sulphur-salicylic acid ointment gives the best results in the treatment of the lid lesions; while the treatment of the rosacea is also said to have a beneficial effect on the lesions."

The blisters of pemphigus may occur on the conjunctivae, and have been known to remain isolated here for several months or years. But a diagnosis of pemphigus cannot be definitely established until lesions appear elsewhere on the body. In 1929 and 1930 I saw a woman with painful erosions in the throat and on the labia minora. Subsequently blisters appeared on the conjunctivae, and later a few scattered blebs were observed on the skin. Death ensued. In cases with lesions limited to the conjunctivae, a provisional diagnosis of pemphigus could perhaps be made with the aid of the phytopharmacologic test of Macht and Pels[7], for which a sample of the patient's blood is required. This test is not infallible.

Zoster, otherwise known as herpes zoster or shingles, may involve the eye or the lids. To quote Ormsby[8]: "*Zoster frontalis* occurs in the area supplied by the supraorbital nerve, which springs from the first branch of the trigeminus. Its lesions extend from the upper eyelid to the vertex, and spread in a fan-shaped figure over one-half of the brow, forehead and scalp. *Zoster ophthalmicus.* This form may be a severe and dangerous manifestation of the disease, being often complicated by agonizing neuralgia, formidable involvement of all parts of the eye, even resulting in panophthalmia, ulcerative keratitis, pyemia, meningitis and death. Typical cases of zoster of this region may not, however, exhibit a single untoward symptom of the disease." Fortunately this is not the usual location for zoster, and the few such cases which I have seen have been uncomplicated.

Impetigo, being distributed over the face as a

rule, may involve the eyelids and often does so. The diagnosis is facilitated by the almost invariable presence of typical lesions elsewhere. Of course, strong ointments of ammoniated mercury and other antiseptics usually employed in treating impetigo may irritate the eyelids, and therefore boric acid ointment or mild yellow mercury oxid ointment had better be applied to lesions in this location. The treatment with these milder applications is a bit prolonged, but the results are good.

Just in passing, I might mention briefly a case of leukoderma of the eyelids occurring in a girl, aged 19. This is a disfigurement which cannot be remedied.

Milia, the tiny epidermal cysts containing sebaceous matter, usually surround and may involve the eyelids. They may be punctured with a small needle and their contents expressed, or they may be more completely destroyed by electrodesiccation with a mild current. Warts, mostly of the thread-like variety, may also occur on the eyelids, and I have encountered lesions of molluscum contagiosum here also. These growths may be removed quickly and completely at one sitting by electrodesiccation. The same treatment, with proper technic, of course, is effective for the removal of granuloma pyogenicum and multiple benign cystic epitheliomas, which are rarely encountered. Fibrous moles also may be removed in the same manner, with excellent cosmetic effects.

Angiomas involving the eyelids are of two types, flat and cavernous. Little can be done for the former, which we call the port wine mark, but the cavernous angiomas may be removed by electrodesiccation, excision or applications of radium, or by combinations of these methods. I recall the case of a girl, aged 18, with a large, redundant and highly disfiguring angioma of the left lower eyelid, which was made quite presentable by the use of radium together with a plastic operation. Each case presents its own problems.

We commonly encounter the slightly raised, flat, yellowish patches of xanthelasma, which may occur on both lids, but especially on the upper. Probably they are due to chemical changes in the connective tissue and endothelial cells, similar to those occurring in generalized xanthoma, rather than in the musculature, as Pollitzer claimed. Formerly these patches were destroyed by applications of trichloracetic acid, several treatments usually being required at intervals of two or three weeks, or by means of solid carbon dioxid, which usually caused considerable local traumatism. During recent years, however, I have been using electrodesiccation successfully in these cases, with a very short spark, which removes the patches completely at one sitting, usually without much discomfort, and with excellent cosmetic results. The only possible undesirable complication following electrodesiccation is keloid formation, and this has ensued in only two of the hundreds of cases thus treated for various conditions, which I have observed during the past 14 years. If keloid should develop, it may be destroyed readily by means of *X*-rays or radium.

Lupus vulgaris and other forms of skin tuberculosis may involve the eyelids. I recall a very extensive case in a negro, aged 40, seen in 1922 at the old Municipal Hospital. The nose, both cheeks and eyelids were extensively involved by a process which was slowly extending with peripheral ulceration and central scarring. Marked ectropion had resulted. The patient's Wassermann reaction was positive, and he had received courses of antisyphilitic treatment in another city, with no benefit to the skin condition. After the secondary infection of the skin had been checked by means of local antiseptics, the active border of the lesion was destroyed deeply by electrocoagulation, and Dr. W. O. Bonser, at the County Hospital, remedied the ectropion by means of plastic surgery, normal skin being taken from the arm. Since negroes are prone to develop keloids, this patient proceeded to do so, and several *X*-ray treatments were required on the arm and in the areas which had been electrocoagulated. The end-result was excellent.

Rarely a syphilitic chancre may occur on the eyelid, usually due to droplet infection of the conjuntiva. The pre-auricular and often also the sub-maxillary lymph nodes of the affected side are enlarged but not tender, a feature which, together with a positive dark-field examination, suffices to confirm the diagnosis. Secondary syphilitic lesions of all types may involve the eyelids, and they are readily diagnosed, as a rule, by the presence of typical eruptions elsewhere. Gumma of the eyelid, however, presents a number of diagnostic difficulties. It may be confused with epithelioma, tuberculosis, dacryocystitis, hordeolum, chalazion, primary or secondary syphilitic lesions and the rarer eyelid affections. It occurs rarely, and does not receive much mention in textbooks. In 1915 Alter[9] of Toledo, described a case in a negro, aged 25, and in 1930 I[10] recorded one occurring in a young man, aged 21, 18 months after he had had a penile sore. In 1925 Heckel and Beinhauer[11] of Pittsburgh, described two cases with a misleading negative serology, and their paper included an extensive bibliography. To quote them: "In differentiation one finds the gumma usually is a cold process, free from surrounding inflammatory reaction, unless complicated, with a true serpiginous or arclike conformity, and has a definite punched-out appearance. It causes thickness of the tissue and is definitely indurated, a boardlike induration which is very characteristic. It usually causes a ptosis of the affected lid. The condition primarily begins in the muscle tissue between the skin and the

tarsal plate or at times even in the skin. The tendency toward discreteness is marked although it may be diffuse, in which condition the lesion may be uniform or characterized by a series of small nodules which become soft, ulcerated and blanched with a tissue destruction giving an aspect pathognomonic of a gummatous involvement. A true gumma does not involve the tarsal plate primarily. In a word, the gummatous process of the eyelids has the same common characteristics as any cutaneous gummatous lesion, and the process of growth—its conformity, induration, softening, ulceration and cicatrization—should be remembered to make the diagnosis more simplified. It again becomes evident that more attention should be devoted to a differentiation of these lesions to avoid any error in diagnosis. It is advised that if the clinical symptoms warrant, in face of the negative laboratory findings such as our cases presented, a therapeutic test be given, preferably in the form of large doses of mercury to further verify or disprove clinical suspicions."

Senile keratoses, cutaneous horns and epitheliomas occasionally occur, especially on the lower eyelid. The keratoses and horns present no diagnostic difficulties and may be removed by a single application of electrodesiccation. Epitheliomas here fortunately are generally of the basal cell variety, with the characteristic pearly border, and do not present the undermined edges seen in tuberculous ulcers nor the firmly infiltrated base of a gumma. In case of doubt, especially in the presence of a positive Wassermann reaction, a therapeutic test may be made for three or four weeks, bismuth or mercury, together with iodides, being employed rather than the arsenical drugs, which tend to stimulate epithelial proliferation and thus may accelerate cancer growth. If the epithelioma has not extended too deeply, involving cartilage or bone, it usually responds very readily to treatment with *X*-rays or radium. I have used this form of treatment in several basal cell epitheliomas of the lower eyelids, and the results have fortunately been uniformly excellent, as well as thoroughly satisfactory from a cosmetic standpoint. One case, for example, occurred in a man, aged 64, an express train engineer. For years his face and eyelids had been irritated by sun, wind, coal dust and cinders, and he presented a kidney bean-sized epithelioma of five years' duration, slowly enlarging, on the margin of the left lower eyelid. Four intensive *X*-ray treatments, at monthly intervals, completed the cure and after four years there has been no recurrence. I recall another case, however, which did not turn out so well. Doctor John Murray and I saw a man at St. Vincent's Hospital with a rather large and deep basal cell epithelioma at the inner canthus. I have seen others in this location which responded well to irradiation, but in this particular case the bone was involved, and surgical intervention was required after radium had failed. I have observed no prickle cell epitheliomas of the eyelids, but it is recognized that in dealing with this condition much more drastic measures are required.

SUMMARY

The delicate skin of the eyelids is especially susceptible to external irritation from poison ivy and other plants, and especially from contact with dusts and vapors. A number of these possible irritants have been mentioned, including strong ointments. The first rule for treatment is the immediate removal of the local irritant by means of soap and water. Soothing and protective agents are then applied to suit the individual case.

The genesis and clinical picture of eyelid eczema have been described, and seborrhea has been mentioned as a complicating factor which must be treated in order to facilitate the cure and aid in the avoidance of possible recurrences.

The eye changes in rosacea, pemphigus and zoster were briefly described, and also impetigo of the eyelids.

Electrodesiccation, with proper technique, was advocated as a rapid and effective means of removing warts, molluscum contagiosum, granuloma pyogenicum, multiple benign cystic epitheliomas, elevated moles, xanthelasma, keratoses and cutaneous horns, with good cosmetic results.

Syphilitic lesions of the eyelids were briefly described, and it was recommended that more stress be placed on the clinical features in diagnosis and less on the Wassermann reaction.

Intensive irradiation with *X*-rays or radium has proved successful for the destruction of early basal cell epitheliomas which have not involved cartilage or bone.

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THE ADVANTAGES AND USES OF THE ELASTIC BAG IN THE MANAGEMENT OF LABOR

By HENRY L. WOODWARD, M.D., Cincinnati, Ohio

FOR more than a century various types of water filled bags have been used to dilate the cervix uteri. The earliest, a bladder used by Schnakenburg in 1831 was soon discarded. A rubber balloon shaped bag invented by Carl Braun in 1851 is still in use and is in modified form the elastic bag that is the subject of this paper. Other bags made of rubber cloth and non-elastic have been urged by De Ribes, Voorhees and others.

The non-elastic bag when filled tightly with fluid is virtually a wedge and does not have the elastic properties of the rubber balloon and traction is often needed to force this wedge through the cervix.

The elastic bag, on the contrary, is pliable enough to change and adapt its shape according to the changes in pressure exerted upon it. When it is placed in the uterus the pressure upon its upper portion causes that portion within the cervix to expand and to exert outward pressure on the cervical ring in a much more positive manner than the non-elastic wedge shaped bag, and for this reason it is only rarely necessary to apply traction.

If traction is used excessively the bag may elongate to a limited extent and slip out through a partially dilated cervix, but traction should rarely be used after the pains are once started and never when the cervix has reached half dilatation. On the contrary, when the bag is pushed out by pressure from above, the dilatation is greater than the circumference of the bag because with each contraction of the uterus the bag is shortened and its circumference expanded.

With the elastic bag it is rarely necessary to use different sizes as the first one used can be large enough to produce complete dilatation of the cervix.

This type of bag can readily be introduced through any cervix which will admit a finger. It is usually introduced by sight, but by touch if need be and I much prefer the gravity to the syringe method of filling the bag. The bag is attached to a Kelly bottle or percolator by a long tube; the bag is filled to the desired size before introduction and then the contents allowed to run back into the container creating a vacuum in the bag so that it folds more readily After introduction the same amount of fluid is allowed to run into the bag and the tube closed by a gauze protected clamp.

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The uses of this bag are very numerous and in all of them in my judgment the elastic bag has many advantages over the non-elastic one.

In the *induction of labor* this type of bag is very efficient especially if the cervix will admit two fingers as is often the case when induction is indicated in the last month of pregnancy. Under these conditions the 7½ or 8 cm. bag is introduced by sight or touch, (the first by preference as the aseptic technique is better). No traction is required. Enough of the neck of the bag projects into the cervix for it to work to the best mechanical advantage. Its presence brings about pressure on the cervical ring and the nerve mechanism about the lower segment very soon starts the pains and the dilatation is very positive and rapid in many cases.

When the cervix will only admit one finger, the bag is readily introduced, but does not fit into the cervix so well and there is often considerable delay in starting efficient pains and sometimes it is necessary to use intermittent traction to stimulate them.

Because of this difficulty it is my practice, when the cervix is tight and it seems as if it will be necessary to induce labor soon, to carry the finger into the cervix and stretch it, even separating the membranes from the uterine wall about the cervix and then giving castor oil. As a preliminary measure this will often bring about a softening and opening of the cervix, making the second step easier. Occasionally these preliminary measures may even start up the labor pains.

In very tight cervices such as are seen at 6 to 6½ months, a preliminary packing with gauze, of the lower segment and cervix through the tubular packer is sometimes necessary.

The method described is most commonly used in toxic patients and of course is much more frequently needed in the last few weeks of pregnancy.

Other reasons for induction such as oversize of the child, overdistention of the uterus from fluid, multiple pregnancy, etc., are usually accompanied by softening and often partial dilatation of the cervix. Its use in the induction of labor for hemorrhage will be taken up separately.

One advantage of the bag, which is not used with sufficient frequency, is as a dilator when, because of faulty position or early rupture of the membranes, the cervix is slow to dilate and undue and sometimes dangerous delay results.

In occiput posterior cases with a cervix far posterior and almost no forewater or when the

membranes have ruptured early, both of which are frequent, the bag is a great help and will often prevent many hours of delay.

In breech cases it is especially useful and almost always used by me if the dilatation is not prompt and efficient and in some cases where there is a tendency to carry overtime, it serves the double purpose of inducing labor and at the same time bringing about prompt dilatation of the cervix and also of the vagina and vulva. In these cases it is very desirable to let the pains push the bag out through the cervix and also through the vulva as the compression of the elastic bag causes a great shortening and a corresponding circumferential widening of the bag. This action can be increased in the vagina by placing a pad and firm binder over the vulva.

In shoulder and face presentation, or other extension positions of the head, where early rupture of the membrane is so prone to occur, the bag aids dilation and also serves to prevent undue escape of the amniotic fluid. This makes version or manual correction of the malposition easier. It also serves to prevent prolapse of the cord.

In the treatment of prolapse of the cord while the cervix is still undilated, it is very useful to prevent the cord coming down again after it has been replaced and also brings about dilatation so that speedy delivery can be undertaken if necessary after its expulsion.

In cases of true rigidity of the cervix and in those cases of moderate disproportion where the cervix appears to be rigid only because the head is held high and does not come down against it even after the rupture of the membranes, the bag can be used to great advantage as a preliminary to the use of forceps or version as a means of delivery.

An uncommon use of the bag which I find valuable is when the cervix has been carried down with the head well into the pelvis and is half dilated or more and manual dilatation is indicated for undue delay. In this condition I much prefer the bag to manual dilatation as it is less likely to bring about laceration It can be introduced and in about the same time required for manual dilatation it will come through the cervix and at the same sitting the delayed head can be extracted.

The bag is of use in antepartum hemorrhage, both hemorrhage from partial or complete separation of the placenta and in placenta praevia.

In premature separation of the placenta when the cervix is soft and will open readily and the condition of the patient justifies the necessary time, the bag can be safely used. In the severe cases, however, or when the cervix is tight, section is much to be preferred.

When the bag is used in either of these conditions, it is better to rupture the membranes as a preliminary step to bring about as much contraction of the uterus as possible and also to avoid pushing up of the membranes and stripping off the placenta by the bag as it is distended. As soon as the bag is filled it should be pulled firmly down into the cervix and the presenting part if possible made to impinge upon the fundus of the bag.

In placenta praevia the bag is only indicated in those patients in whom the cervix is very soft and partly dilated, or those in whom the hemorrhage is severe enough to make immediate control necessary.

When the cervix is closed in a primipara and especially if it is of the central variety, Caesarean section is much better.

For immediate control of hemorrhage in the home or elsewhere, a fully distended bag in the vagina held in by a firm binder and pad, will make counter pressure against the bag of water and control the bleeding area until other methods can be prepared for.

In using the bag where the cervix is partly dilated and the placenta is only partially covering the os, the membrane should be ruptured, the bag inserted beyond the placental edge and then pulled firmly into the cervix. If the placenta covers the os so that the bag cannot be carried past it, a finger or blunt instrument must be carried through the placenta and the bag carried through this opening. Under these conditions it is especially necessary to pull the distended bag well down into the cervix to compress the placenta and sometimes traction is even needed until the pains are well established to control the bleeding.

In all hemorrhage cases it is essential that the bag be very carefully watched so that its expulsion from the cervix is immediately discovered to prevent blood accumulating behind it.

There are certain dangers in the use of the bag, but they are far outweighed by its advantages in the conditions indicated.

These are, first, the added danger of infection, but this can largely be controlled by a proper technique.

The danger from rupture of the bag is practically nil if a sterile fluid is used to distend it and never air.

Sometimes the bag displaces the head and brings about a malposition. This is much more apt to happen in early cases where the entire bag goes inside the cervix and the child is small and therefore easily displaced.

In cases of malposition this ceases to be a disadvantage, as it serves to dislodge a shoulder, brow or face and make its correction easier. One danger of the bag should never be forgotten and that is pressure upon or prolapse of the cord because of displacement of the presenting part. The possibility of the first should always be borne in mind and just as soon as the bag is in place the fetal heart should be checked. This should also be done immediately upon the expulsion of the bag.

It is my practice immediately after the expul-

sion of the bag to make a careful vaginal examination and after determining the position and the absence of prolapsed cord or small part to rupture the membranes artifically. Otherwise it not infrequently happens that the pains will stop and in any case the membranes have lost their usefulness when dilatation is complete.

If in this examination a malposition is discovered, it can often be remedied at this time or version done if necessary for prolapse of the cord or other indication.

In conclusion I wish to say that my main reason for speaking on this rather elementary subject is to urge those not in the habit of using the bag to use this simple and safe method more frequently and thus save many of their patients useless delay and often manual dilatation and cervical laceration from delivery through an unprepared cervix. Also I wish to urge those who use the non-elastic bag almost exclusively to give the more generally applicable elastic bag a trial.

MELROSE BUILDING.

ULCERATIVE COLITIS

Etiology and Management

By H. F. HOWE, M.D., TOLEDO, OHIO

CHRONIC ulcerative colitis is a systemic disease with local bowel manifestations, clinically characterized by diarrhoea with pus and blood in the stool. My clinical experience and inability to recover the organisms responsible for bacillary dysentery would lead me to believe with others that this disease is not chronic bacillary dysentery. The increased prevalence and recognition of amoebiasis in this longitude have made important the differentiation of chronic amoebic colitis. I wish to emphasize that my remarks are not concerned with that group of cases known as irritable colon or mucous colitis which we erroneously dignify with the term colitis.

This presentation of only twenty cases of this disease observed over a six-year period may be of little scientific value but this study and a review of the literature have impressed me with the fact that progress is being made in its management but that much has yet to be decided as to etiology and therapy.

Frequent rectal discharges have been the principal complaint in all cases. The onset may be gradual with slight increase in the number of bowel movements associated with impairment in general health. Fifty-five per cent have had acute illnesses with diarrhoea, crampy abdominal pain, tenesmus, blood in stool, and high fever; 85 per cent gave a history of recurrent attacks of diarrhoea with pus and blood in stools. Two patients in this series complained largely of frequent desire to defecate with great difficulty in expelling small amounts of formed stool and on most attempts passing only pus and possibly blood. These cases have shown on examination early stricture formation before much evidence of active ulceration. A small percentage of cases—only 5 per cent in my series—succumbed during an acute fulminating toxic condition with diffuse involvement of the entire large bowel unaffected by all forms of treatment. Fifteen to 20 per cent of cases could be classified as mild with only recurrent diarrhoea of a few days' duration and only small amounts of blood and mucous in the stools. In some the complaint was hemorrhoids.

To put meaning into our management of these cases we must appreciate the multiplicity of etiological factors. Lowered bowel resistance or susceptibility to ulceration is part of the constitutional background. This constitution has to do largely, I believe, with an inferior control by the vegetative nervous system with resultant spasm and hyper-motility. Mallory states that spastic constipation, mucous colitis, and ulcerative colitis are progressive stages of the same disease. Ninety per cent of my cases complained of nervousness. This was demonstrated by fears, irritability, anxieties, and excessive complaints and depressions. They present a high percentage of social maladjustments, divorces, etc. One patient stayed in bed for eight months without any particular bowel symptoms, but finally made an adjustment to a domestic situation and became again a useful citizen. These people, many of whom are infantile in their mentality, have real psychogenic problems and their response by diarrhoea is an infantile one.

The work of Haskell and Cantarrow[1] would indicate the possibility of a nutritional error with altered calcium distribution in the tissues and resulting disturbance in vegetative control. A number of cases treated by calcium and parathyroid successfully lend some support to this idea.

I am sure that the habitual use of cathartics is a factor in producing lowered bowel resistance. Seventy-five per cent of my cases had been constipated previously, some markedly so.

Felsen[2] reports definite hypertrophy of plexuses

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of Meissner and Auerbach in sections from bowel wall. He believes that this indicates some disturbance in the nervous mechanism of the colon with secondary changes lessening the protective forces of the mucosa.

In this age of vitamin promotion we must also remember that vitamin deficiency is often an etiological factor in ulcerative conditions of the gastrointestinal tract. Dr. Mackie[3] recently reported a series of 75 cases of ulcerative colitis in which a high percentage of cases showed definite manifestations of vitamin deficiency. These were principally in the form of skin or mouth lesions. He has also demonstrated *X*-ray changes in the form and motility of the small bowel in cases of ulcerative colitis and believes that these changes may be responsible or accompany an inadequate absorption of vitamins even if the intake is within the normal. Reviewing my cases I find only 20 per cent with signs possibly due to vitamin deficiency.

Colon films on several of my patients do show an unusual reflux of barium into the terminal ileum due evidently to atonicity of this portion of the small intestine and perhaps part of the picture Mackie describes. It may be significant that 65 per cent of this series are charity patients with less chance for a varied diet. In Vienna ulcerative colitis is a common finding at autopsy and believed largely due to diet deficiency.

Allergic states may be a factor in some cases but I have been unable to demonstrate this.

I am convinced that the exciting factor is infection. In my experience recurrences are particularly likely to follow respiratory infections. In thirteen cases in which we attempted to isolate an organism from the colon, in all but one case a gram positive diplo-streptococcus similar to the organism described by Bargen of the Mayo Clinic was isolated. In many cases this organism was recovered several times. Cultures were made by securing material directly from the ulcers through the sigmoidoscope and grown on dextrose brain broth. In two cases at autopsy we recovered this organism from the bowel wall.

Controversy as to the specific nature of this organism and as to its role in this disease constantly appears in the literature[4] but the continued weight of evidence emanating from many centers reaffirms my impression that the diplostrept is the exciting organism and that the disease may well be called bacterial ulcerative colitis.

The disease process in a high percentage of cases begins in the rectum and extends to involve the entire colon. In about 25 per cent cases ulceration never extends beyond the rectum. In two cases of the group the *X*-ray findings would indicate extension as far as the splenic flexure.

The diagnosis is never obvious. The acute fulminant attack must be differentiated particularly from amoebic or bacillary dysentery. In amoebic dysentery the stool is loose, watery, mixed with feces and some blood. Recovery of the motile amoebae is the only positive means of differentiation. In two severely ill patients observed this year in which amoebiasis was suspected but could not be proved, emetine therapy given with prompt improvement made the diagnosis and is justified in severely ill patients.

In bacillary dysentery the rectal discharge is almost entirely mucous, perhaps mixed with blood. The characteristic stool of ulcerative colitis is pus streaked with blood or blood clots. Stool culture will usually show the organism of Shiga or Flexner in this disease.

The ordinary chronic recurrent case of ulcerative colitis shows periods of uncontrolled diarrhoea with anemia and definite evidences of chronic invalidism. Again, this picture cannot be clinically differentiated definitely from amoebic colitis. The proctoscopic picture in ulcerative colitis is significant and usually diagnostic. Early or mild recurrent cases show a diffuse granular appearance. Later multiple superficial ulcers appear with granular mucosa between. Cases of months' or years' duration show the mucosa replaced by ulceration and granulations with narrowing of the lumen.

In amoebic colitis the ulcers are as a rule discrete with normal mucosa between. Secondary infection and recurrences finally produce a very similar proctoscopic picture. One should require careful examination of at least three liquid stools or six formed ones before deciding that the case is not one of amoebic colitis. I have observed two cases of recurrent severe attacks of diarrhoea requiring hospital care which could not clinically be differentiated from ulcerative colitis in which amoebae were found originally and repeatedly in the stool with each recurrent attack. (This is a reflection on the amoebic therapy which they had received which consisted of repeated courses of emetin only.)

Motile amoebae are found most easily and in greatest numbers in scrapings from the ulcers in the rectum obtained through the sigmoidoscope. It must be remembered that a large number of cases of amoebiasis show no rectal involvement as this disease most commonly affects the right half of the colon. The *X*-ray findings during this stage are often diagnostic. The narrow shortened irregular appearance of the entire colon or of localized segments being characteristic and differentiate it from other types of colitis.

I would like to call to your attention the fact that six cases of this series were operated for hemorrhoids on account of bleeding without sigmoidoscopic examination and without evidence on the record that the operator was aware of the existence of the ulcerative condition of the colon

which was more than likely the real source of the hemorrhage. In one case death occurred from a very acute colitis within one month after a hemorrhoidectomy, and in a recent case the surgeons after having all preparation made for the hemorrhoid operation, inserted the sigmoidoscope, discovered the real condition, and left the insignificant hemorrhoids alone. The moral in this story is that hemorrhoidectomy should not be done except for bleeding which is without a doubt from piles, without sigmoidoscopic examination.

The treatment of ulcerative colitis is not standardized. Management is a better word than treatment because results are not obtained unless all factors which influence the well-being, physical and mental, of the patient are considered. Rest is important and while temperature and frequent stools are present, this should be in bed. Encouragement and psychotherapy directed towards the relief of fears and problems of all sorts should be practiced. These patients are cooperative and willing to follow all suggestions for therapy as they realize the seriousness and chronicity of their complaint. Although depressed easily they are apparently easily encouraged and this must be one's constant aim. Bed rest should not be continued too long. Many cases with eight or ten stools a day do well ambulatory, providing fatigue is avoided. "Employment is Nature's best Medicine" is still as true today as when uttered by Galen. Sunbaths should be used during convalescence.

DIET

During the very acute stages fluids by vein or subcutaneously may be necessary. Clear warm liquids allowed first; then soft low residue bland diet with foods such as cereal, rice, potato, egg, meat are gradually added. Additions are made depending on the severity of the disease until a diet is built up to contain approximately 3000 calories, restricting, of course, rough foods and condiments, but containing sufficient vegetables and fruits, raw and cooked, to provide vitamins and minerals. I routinely prescribe Brewer's yeast and a preparation of Vitamin A and D such as haliver or codliver oil with viosterol. I will not forget the case of a young colored girl first seen five years ago with a very acute diarrhoea with blood and pus in the stool. In attempting to control her diarrhoea I allowed only clear liquids. She continued for several days with no improvement and kept crying for food, finally more or less in desperation I allowed full hospital diet. The following days she was much better and left the institution in a few days. Of course this may have been a coincident, spontaneous remission.

I have used small repeated transfusions for the acute or chronic disease with marked anemia with beneficial results.

I have found paregoric and bismuth salts of some value in the acute stages. Also mixtures of equal parts of Kaolin and barium sulphate. These drugs must all be given in huge doses. During the chronic course drugs are not given to control diarrhoea. Gentian violet grs. ½ in enteric tablets given three to five daily I believe useful in some cases.

The concentrated antibody solution prepared from the diplostreptococcus should be given to all acutely ill patients. I have seen two patients dangerously ill show marked and prompt improvement. We give this as outlined by Bargen, starting with a small intracutaneous dose and increasing by 1/10 cc. each eight hours at first until two to three cc. are given at a dose, depending upon the reaction. For economic reasons I have not given this serum to chronic cases. Dr. Bargen[5] has found its use in all cases of definite benefit.

Autogenous vaccine is given in repeated courses to all patients. I have given courses two to three times a year and have had no difficulty in repeatedly obtaining a gram positive diplostreptococcus from which to make a vaccine.

We routinely remove or treat focal infections present in tonsils, teeth, or sinuses at such time as the patient's condition warrants such interference.

The work of Andresen and D'Albora on the use of mercurochrome intravenously appeared in October, 1933. I have used this substance since that time in two cases only. Both showed improvement which could not be due to any other factor. One case of five years' duration with an average hemoglobin of 50 per cent showed for the first time a hemoglobin of 80 per cent and a bowel wall which looked almost normal.

Only two cases of this series have had surgical therapy. One case of years' duration with a recto-vaginal fistula died of peritonitis shortly after ileostomy. The other case had a partial colectomy and died two years later of a continuation of his colitis and toxaemia. Because of the high operative mortality and because surgical treatment does not cure the ulcerative condition of the colon even if it does allow irrigation, I am reserving this for those few cases of local segmental disease or those with complications such as fistulae, perforation, or marked anal infections. A living patient who is at least fairly comfortable with some diarrhoea is better than a surgical death and is probably better than to live with a permanent ileostomy.

Of our series we find 30 per cent well; 35 per cent are improved and able to carry on their usual occupation; 15 per cent are improved but unable to work; 20 per cent are dead of peritonitis, chronic exhaustion and toxaemia or acute illness. The improved cases must be constantly on guard to prevent relapses which are likely to follow respiratory infections, changes in weather,

fatigue, emotional disturbance or irritation of the colon by improper eating or drinking.

I would like in conclusion to have you remember that chronic ulcerative colitis exists relatively commonly and that its management should be so comprehensive as to include all possible etiological and modifying factors and that by so doing approximately 80 per cent of the sufferers with this serious and disabling disease may be benefited which is indeed an accomplishment worth striving for.

2001 COLLINGWOOD AVENUE.

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DISCUSSION

W. S. HENDERSON, M.D., Akron: In the past year the epidemic of amebic dysentery, disseminated from Chicago, has forcibly directed our attention to intestinal ulceration. The subject of Dr. Howe's paper is chosen most timely and has been presented in a clear-cut and concise manner. If we pause to consider, there is an amazing similarity between these conditions. The onset symptoms, clinical manifestations and objective findings are much the same. We have in each case intestinal ulceration, one caused by a definite organism, (ameba histolytica), with a more or less standardized method of treatment. On the other hand continued controversy has persisted as to the etiology and many and varied are the methods of treatment.

With sound reasoning Dr. Howe has emphasized the fact that idiopathic ulcerative colitis is bacterial in origin. It seems probable that Bargen with his demonstration of the diplostreptococcus commonly found in these ulcerative lesions, has most closely approximated the true etiological factor. I have not been as successful as Dr. Howe in recovering this type of organism from lesions in all cases. Other types of streptococci have been recovered, however, and would appear to be the causative agent. The predisposing factor for pathogenesis may be due to a lack of anti-bodies on the part of the individual suffering from the disease but might possibly also be due to a lack of internal secretion in the colon, itself. It has been demonstrated that these organisms pass through the mucosa and the ulceration is produced in the sub-mucosa either from toxin or emboli. The question is raised will these organisms pass through the mucosa without producing disease? We know that in certain types of colon irritability the mucus secreted, acts as a protective agent clinging to the bowel wall until excessive amounts produce a partial obstruction. Further knowledge of the physiology of the secretion of the colon will, I feel, help to solve this problem.

If agreement is being reached that this disease is bacterial in origin, then a definite rationale of treatment should be arrived at. In this series of twenty cases 30 per cent were cured although 80 per cent were definitely improved. These figures compare favorably with other reports throughout the country, but still these figures are very low compared with results of treatment of other systemic disease of a bacterial origin. Many observers will question the statement that this is a systemic disease. Dr. Howe has emphasized the importance of treating the individual as a whole and not only the local manifestations of the condition. During the acute state I find the most favorable results are obtained from a low residue, high vitamin, high caloric diet, anti-spasmodics by mouth, vaccine therapy, and medicated retention enemas of gentian violet and neutral acriflavine. I wish to emphasize that the physician's responsibility has not ended when the lesions and symptoms disappear, but that the patients must be kept under continued observation for a sufficient period of time and their general strength and resistance be maintained and built up so as to prevent a recurrence of the disease.

V. C. ROWLAND, M.D., Cleveland: The exact etiology of ulcerative colitis is still somewhat obscure. The specificity of the diplococcus of Bargen is not established and no other one factor can be regarded as definite. Various generalized infections and gastro-intestinal infections including bacillary dysentery may lead to a chronic ulcerative colitis even after the primary organism has died out. Sympathetic imbalance and nutritional deficiencies probably play a part. Constipation, per se, however I do not believe is a major factor in the disease. In many instances a general lowering of resistance such as by anemia or as seen sometimes in the puerperal state permits of an ascending infection upward from the anal region.

Early diagnosis and good conservative treatment directed toward all the possible etiological factors including bed rest and vigorous treatment for anemia will control the disease in its earlier stages in the majority of cases. High vitamin-protein, bland diet and the vaccine therapy may also help. The possibility of food allergy should be kept in mind. Nothing can take the place, however, of the rest program and a regimen such as might be carried out in tuberculosis. Intravenous dyes have been reported on very favorably in the last couple of years but certainly there are conspicuous failures in their use.

In late and neglected cases when conservative measures have failed and a very acute condition exists threatening life and especially when associated with hemorrhage, transfusion and a quick ileostomy may be a life-saving procedure. It may have to be permanent or followed by a colectomy but as Judd has said, operations on the infected colon are to be avoided whenever possible. In some quarters there is considerable enthusiasm for colectomy and good results are sometimes obtained, but there are also dismal failures. It should be remembered too that some cases have ulceration a considerable distance up the ileum. Mackie has reported lesions throughout the small intestine.

A greater familiarity with the formidable nature of fully developed ulcerative colitis would lead to earlier diagnosis and more thorough treatment in the early stage of the disease such as is urged in tuberculosis and probably with similar advantages.

HYPERTENSION WITH RELATION TO CAPACITY FOR WORK

By A. G. CRANCH, A.B., M.D., Cleveland, Ohio

ANY discussion of this subject necessarily deals with such variable and complex factors that an attempt to present exact figures or fixed rules would be futile. A general review will be given of the more important points involved, and an attempt made to correlate these with working efficiency and safety.

In considering the frequency of cases of hypertension among the industrially employed, we are at once confronted with the question of accuracy in our figures. Many years ago when I first started to make routine examinations of applicants for employment one of the most striking things noticed was that great numbers of men, apparently otherwise in good health, showed a most unusually rapid pulse rate, often over one hundred. On rechecking a considerable number of the more marked cases, a few days later, practically all were within normal limits. This tachycardia was apparently due chiefly to strange surroundings and procedure and the resultant excitement.

The same holds true to a large extent with blood pressure determinations, especially when we realize that they are often being made for the first time. At times I have found blood pressures of say, S. 150 to D. 90 in otherwise apparently average normal young men, who on repeated later examinations would show quite regularly pressures around S. 120 to 125 and D. 80 to 85. With this in mind, we should be careful in deciding how many in a group of employes really show significent hypertension.

Having satisfied ourselves that a true hypertension is present some sort of standard or classification is very desirable. Dr. Wychgel[1] in his study a few years ago adopted such a classification, which is very practical, and his report gives some idea, also, of the frequency of this condition as found in 354 steel workers over 54 years old. This group showed presence of hypertension in 73 per cent. These cases were divided into three classes as follows:

First Degree: (47 per cent). Pressure of S. 150 to 170, D. 90 to 110. Allowed to continue at moderate work, medical attention advised, and if not improved in one year placed in next class.

Second Degree: (22 per cent). Pressures of S. 170 to 200, D. 110 to 120. Work definitely restricted both as to physical or mental strain.

Third Degree: (4 per cent). Pressures of S. over 200, and D. over 120. In these cases retirement from active work was advised.

Read before the Section on Public Health and Preventive Medicine, Ohio State Medical Association, at the 88th Annual Meeting, Columbus, October 4-6, 1934.

Kirk[2] in a somewhat similar study, found in 105 employes over 55, 63.8 per cent with hypertension, and in 422 under 55 years, 36 per cent similarly affected. He quotes Fahr as giving 50,000 annual deaths in this country from heart conditions associated with hypertension, and in one year noting a total of 140,000 deaths from arterial hypertension and its consequences.

Our own cases, occurring among employes engaged in lighter work than those of Dr. Wychgel's series, show relatively a lower percentage though about the same proportion in each class.

Something of the importance of hypertension is evident in the statement by Elliott that 10 per cent of those over 40 show this condition, and by Cabot that 77 per cent of all heart disease without valvular lesions is due to hypertension and associated cardiovascular changes. This is quoted by Kirk[2]. But the significance of hypertension is not as a disease entity. Like fever it is only a symptom. The danger lies in the underlying conditions. For a while an "essential hypertension" was described, usually supposed to be hereditary, and not indicative of physical impairment. Now it seems probable even these "essential hypertension" cases do indicate some associated abnormality which sooner or later demands attention. Later writers on the subject stress more and more the importance of the associated conditions, as of the utmost diagnostic importance, and as indications for treatment.

The fitness for work of a man with hypertension cannot then be determined so simply as by noting his blood pressure at the time of examination. A careful search should be made for the important associated conditions of which it is but the symptom. These are so varied that each case requires individual study. Such a study must be made if any reasonable estimate is to be made of capacity for work, or what is often equally important, if a prognosis is required. As DuBray[3] of San Francisco recently stated, the study of the case should be based on the following factors: 1—Heredity, 2—Environment, 3—Habits, both mental and physical, 4—Development of symptoms, and 5—Objective signs. The prognosis depending upon: 1—the etiological factors discovered, 2—the stage of the disease present, and 3—the degree of impairment of cardiac function. This is in accord with the observations of many later writers and our own experience—the degree of cardiac impairment is of very great practical importance.

As for etiology and associated conditions. The degree of blood pressure depends upon (1) the

heart as a pump, (2) the elastic coat of the large arteries changing the intermittent pumping rhythm to a steady flow, (3) the small arteries acting as a control of the flow, (4) the capillary bed or irrigation field, and (5) the drainage system of veins and lymphatics. Anything disturbing the normal interrelation of these factors may affect the blood pressure.

Heredity must be considered, not because hypertension is directly inherited, but because a predisposition is very noticeable in certain familes. Hard physical work, or the steady mental strains and stresses of modern life, may not directly cause hypertension, but added to inherited predisposition or other factors may bring it about. Should it appear, these physical and mental strains tend to aggravate the condition. The frequent relief of hypertension through regulation of diet, attention to focal infections, and the use of glandular therapy, point clearly to the importance of diet, infection and glandular dysfunction as etiological factors. Infection in the lower gastrointestinal tract should be considered, as well as in the teeth, tonsils, sinuses, etc. Some consider thyroid and adrenal disturbance of much importance.

Many things in environment certainly affect the development of the condition. Excessive physical labor and exposure to metallic poisons such as lead, predispose. Conditions of strife, antagonism and the like, at work or at home, and lack of opportunity for rest and relaxation are detrimental. Faulty habits, especially over-eating, over-stimulation, "the strenuous life" without rest, and lack of sleep, all play an important part.

Symptoms and objective signs of the condition belong rather to associated disease. Sometimes only paleness and easy fatigue are noted. Sometimes gastrointestinal symptoms—"dyspepsia", etc. Gastrointestinal symptoms, especially vomiting, coming on suddenly in the later stages of a case, are often of grave significance and may be the forerunner of a cerebral hemorrhage. Arteriosclerosis appears sooner or later in practically every case. If peripheral it may produce coldness of the extremities, claudication, paresthesias, and even localized gangrene. When peripheral, the pulse pressure may be markedly decreased, through elevation of the diastolic pressure, disproportionate to that of the systolic. The elevation of the diastolic pressure is of great importance. Some observers have noted as great a mortality in those with a diastolic pressure of 110 as in those with a systolic pressure of 200. Wychgel[1] considered a diastolic pressure of 120 the limit of safety for any work, and those with more to be retired.

Some years ago great stress was put upon the relation between hypertension and renal disease, and also upon its association with arteriosclerosis, and consequently with cerebral hemorrhage. Both relations are very important but there seems a growing recognition of the very frequent presence of myocardial damage in patients with hypertension. Whatever the cause of the hypertension, whether functional or organic, the brunt of the condition is borne by the heart and blood vessels first, and by the kidney later. Some authors, as Strauss[4] of New York, list hypertension as the greatest single cause of myocardial insufficiency, and the majority of other causes are also common to hypertension. Therefore, in making an estimate of functional capacity and a prognosis in a case of hypertension, particular attention must be given to evidences of myocardial damage. The early detection of this rests rather in symptoms than objective signs. Reaction to physical exertion must be noted, especially easy elevation of the pulse rate with slow return, after exercise. Dyspnoea, especially that coming on at night, is very important. Hypertrophy, or dilation of the heart, should be noted. There is often marked accentuation of the aortic second sound.

Among associated conditions tending to make the outlook less favorable in a case of hypertension might then be given the following: Myocardial disease; arteriosclerosis, especially involving the small vessels as the coronary arteries, cerebral or renal vessels; renal disease; diabetes; syphilis; goitre; obesity; focal infections, including those of the lower intestinal tract; exposure to lead; habits of over-eating and over-use of stimulants; mental and nervous excitability, with want of proper rest and relaxation; constipation —and probably many others.

Enough has been said to emphasize the complexity of the problem presented by hypertension and, therefore, the difficulty in setting any definite standards for the employment of those showing the condition. Certainly no arbitrary standard can be set up based simply on a blood pressure determination. Wychgel's classification furnishes probably as satisfactory a basis as any suggested. Our own experience has been chiefly in connection with the examination of older employes, and the question chiefly involved is determination of suitable work. Generally speaking, the basis is as follows: Hypertension with early myocardial changes, lighter physical work is indicated. With arteriosclerosis, not only lighter physical work, but usually work involving less responsibility. Arteriosclerotics are placed also where any such thing as a cerebral or coronary accident would not be likely to endanger others. Those showing only an unusually high systolic pressure and free from signs of accompanying disease, and no tendency toward steady increase of pressure, may often continue with apparent safety at their usual work. All cases showing any noticeable increase above the usually accepted standards, are urged to consult their own physician. Our great difficulty has been in persuading such patients, who

are often symptom-free, to give their condition proper attention.

One of the most important practical points in the hypertension case is continuing supervision. Response to treatment must be noted at intervals to insure continued safe relation between work and the patient's capacity. Sometimes suitable work may be available for several years. In other cases leave of absence must be given for a time and in a few cases, not responding to treatment, or showing other serious changes, retirement must be arranged. As far as possible we try to cooperate in the treatment of these cases by providing suitable work and environment.

SUMMARY

Hypertension is probably more common in industry than is generally supposed. Care must be taken to avoid error in detection of cases. Itself only a symptom, associated conditions must receive the greatest consideration. From point of view of capacity for work, myocardial and arteriosclerotic changes are most important. Standards based primarily on blood pressure determinations are not satisfactory. Successful placement of hypertension cases is only possible through continuing supervision.

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—OSMJ—

NEW BOOKS

Annual Reprints of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1934, with the Comments That Have Appeared in The Journal. Cloth. Price, $1. Pp, 135. Chicago: American Medical Association, 1934.

Each succeeding volume of reports of the Council reveals more of the long and successful fight in the interest of rational therapeutics. The Council is no longer chiefly concerned with noisome proprietaries and yet this latest volume contains reports on such articles as "Vita-Cell," a secret preparation marketed with exaggerated claims, and "Raylos," a shotgun preparation marketed in a way to promote its ill advised use by the public. Most of the "unacceptable" reports in this volume are concerned with products that may have some merit but are not offered to the public in a way which experience has taught the Council is necessary before a therapeutic agent is acceptable. Such products are Iodine Dusting Powder (Sulzberger), rejected for lack of clinical evidence of its advantage over one of its constituents; Pernoston, rejected because of lack of clinical evidence to justify routine intravenous injection of barbital compounds; Di-Hydranol, a claimed bacterial agent proposed for use as an "intestinal antiseptic," a claim not supported by sufficient clinical evidence; and Squibb Adex Tablets, a product containing a concentrate of vitamins A and D, for which the firm could not agree to adopt a more informative name.

To those who have followed the Council's investigation of B. acidophilus therapy, the report "Acidophilus Bacillus Liquid-Mulford and Mulford Acidophilus Bacillus Block Omitted from N. N. R." will be of interest. The Council has apparently not yet reached an ultimate conclusion concerning acidophilus therapy, but it has for years held that no product could be expected to be of value unless it could show at least one hundred million viable B. acidophilus organisms at the "date of expiration." Competent bacteriologic examination showed that the two preparations here reported were inferior to this standard. Further grounds for omission were the failure of the manufacturer to comply with certain stipulations in regard to labels and advertising. Another noteworthy omission is that of Alpha-Naphco and its dosage forms, omitted because the Council on reconsideration found that it is a weak antiseptic.

The Council also issues preliminary reports, which define the status of new preparations for which the evidence is not yet sufficient to justify their presentation to the medical profession generally. Preliminary reports do not imply rejection but rather postponement of consideration until more evidence is reported by competent investigators. These reports are the outposts of therapeutic progress and as such are valuable sources of information to physicians. In this volume there are preliminary reports on Adrenal Cortex Extract, concerned mostly with scientific terminology, Cysteine Hydrochloride, Dihydroxy-Anthranol (Anthralin), Gastric Mucin, Hemoprotein (Brooks), Phenylmercuric Nitrate and Phenylmercuric Chloride.

Illustrative of the Council's efforts to keep those concerned informed of the basis for its actions are the "Recent Revisions or Elaborations of the Council's Rules of Interest to Manufacturers and the Medical Profession," which have appeared in the last two volumes. These inform the profession of the various problems which arise and the care given to their consideration. To be commended also is the "Report on Sterility of Ampule Preparations."

—OSMJ—

Definite Upswing in Ohio Birth Rate Noted by Bureau

According to a report issued by I. C. Plummer, chief of the Division of Vital Statistics, State Department of Health, there is a definite upswing in the Ohio birth rate in contrast to a steady decline for the past decade.

He said there was an increase of 4,073 last year as compared to 1933, and predicted a further gain for 1935.

Pointing out that the records showed 95,962 births in 1933, as contrasted to 117,611 in 1930, and an increase to 100,035 in 1934, he asserted that the birth rate, like everything, travels in a cycle.

Mr. Plummer attributed the present upward trend in the birth rate to improved economic conditions, and blamed the former drop on the depression coupled with "cosmopolitan housing, automobiles and the growing respect for religious tradition."

EIGHTY-NINTH ANNUAL MEETING

NETHERLAND PLAZA, CINCINNATI, OHIO

Wednesday, Thursday and Friday, October 2, 3 and 4, 1935

Condensed Summary of Program

ALL SESSIONS AT THE NETHERLAND PLAZA HOTEL (Fourth Floor)

Wednesday, October 2, 1935

Wednesday Morning

8:00 A. M.—CLINICS AT THE CINCINNATI HOSPITALS.
Program of the clinics may be obtained by calling the Cincinnati Academy of Medicine, Parkway 2345. No clinics will be scheduled at any other time during the meeting.

Wednesday Afternoon

1:00 P. M.—FIRST GENERAL SESSION. Hall of Mirrors. Opening session of the House of Delegates.

3:00 P. M.—SECOND GENERAL SESSION. Hall of Mirrors. James B. Herrick, M.D., Chicago, Guest Speaker.

3:45 P. M.—THIRD GENERAL SESSION. Hall of Mirrors. Frank H. Lahey, M.D., Boston, Guest Speaker.

6:00 P. M.—DINNER in honor of visiting women physicians, given by the Medical Women's Club of Cincinnati.

Wednesday Evening

8:15 P. M.—FOURTH GENERAL SESSION. Hall of Mirrors. Annual Addresses of President and President-Elect.

Presentation of Past President's gavel to Retiring President.

Address by Morris Fishbein, M.D., Editor of *The Journal of the American Medical Association.*

Informal reception.

Thursday, October 3, 1935

Thursday Morning

9:00 A. M.—MEDICAL SECTION. Pavilion Caprice.

SURGICAL SECTION. Hall of Mirrors.

OBSTETRICS AND GYNECOLOGY. Parlors A, B, C and D.

PEDIATRICS. Parlors E and F.

EYE, EAR, NOSE AND THROAT. Foyer of Pavilion Caprice.

NERVOUS AND MENTAL DISEASES. Parlor G.

Thursday Noon

12:00 LUNCHEON AT NETHERLAND PLAZA for Past Presidents of State Association. Class and fraternity reunions.

Thursday Afternoon

1:30 P. M.—FIFTH GENERAL SESSION. Hall of Mirrors. R. Wesley Scott, M.D., Cleveland, and Leslie L. Bigelow, M.D., Columbus.

3:00 P. M.—SIXTH GENERAL SESSION. Hall of Mirrors. Program presentation by members of the Faculty of the College of Medicine, University of Cincinnati—A. R. Vonderahe, M.D., Wm. Millar, M.D., Stanley E. Dorst, M.D., Leon Schiff, M.D., and Glenn E. Cullen.

Thursday Evening

7:00 P. M.—SEVENTH GENERAL SESSION. Hall of Mirrors. Annual Banquet.

Address of Welcome by Hon. Russell Wilson, Mayor of Cincinnati.

Highlights of First State Medical Meeting held 100 years ago by Jonathan Forman, M.D., Columbus.

Guest Speaker. "A real surprise is in store for you."

Friday, October 4, 1935

Friday Morning

9:00 A. M.—EIGHTH GENERAL SESSION. Hall of Mirrors. Final session of House of Delegates.

11:00 A. M.—NINTH GENERAL SESSION. Hall of Mirrors. Palmer Findley, M.D., Omaha.

Friday Afternoon

12:00 P. M.—ORGANIZATION LUNCHEON. Pavilion Caprice. For officers (including past-presidents), councilors and committee members of State

Association; delegates to A.M.A.; presidents, secretary-treasurers, legislative and medical defense committeemen, correspondents to *The Journal* of county medical societies; members of the House of Delegates; section officers; chairmen of Cincinnati committees on arrangments.

Address: "Administration of the Ohio Workmen's Compensation Law", by Mr. A. D. Caddell, secretary, State Industrial Commission.

2:00 P. M.—MEDICAL SECTION. Pavilion Caprice.

SURGICAL SECTION. Hall of Mirrors.

OBSTETRICS AND GYNECOLOGY. Parlors A, B, C and D.

PEDIATRICS. Parlors E and F.

EYE, EAR, NOSE AND THROAT. Foyer of Pavilion Caprice.

PUBLIC HEALTH AND PREVENTIVE MEDICINE. Parlor G.

GENERAL SESSIONS

Opening Session

Wednesday, October 2, 1:00 P. M.

Meeting Place—Hall of Mirrors, Fourth Floor, Netherland Plaza Hotel.

This session is combined with the first session of the House of Delegates. See Page 681.

Second Session

Wednesday, October 2, 3:00 P. M.

Meeting Place—Hall of Mirrors, Fourth Floor, Netherland Plaza Hotel.

SOME PROBLEMS OF MEDICAL DIAGNOSIS—by James B. Herrick, Chicago.

The many recent additions to medical knowledge increase the demands on the physician as regards diagnosis. A complete diagnosis often requires extended study of the case with help from laboratory, instruments of precision and specialists. Attending this ideal diagnosis are difficulties, such as the requirements of exceptional knowledge, much time and considerable expense. Suggestions as to ways of overcoming these difficulties, e.g. by group practice and cooperation with laboratories. In a large proportion of cases these extended studies are not necessary. They may even be harmful to the patient. There are considered the non-essentials of diagnosis. In the last analysis the solution depends on the knowledge, experience and good judgment of the doctor.

Third Session

Wednesday, October 2, 3:45 P. M.

Meeting Place—Hall of Mirrors, Fourth Floor, Netherland Plaza Hotel.

1. NEWER ADVANCES IN HYPERTHYROIDISM AND HYPERPARATHYROIDISM—by Frank H. Lahey, Boston.

The various types of hyperthryroidism will be discussed; activated hyperthyroidism, apathetic hyperthyroidism, hyperthyroidism in children and acute thyroid crises.

Some of the measures which have been evolved in the management of these cases in an experience with thyroid operations now mounting to something over thirteen thousand, six hundred thyroid operations. Some of the complications of hyperthyroidism will be discussed, such as, hyperthyroidism and diabetes, hyperthyroidism and cardiac states, the end-results in total thyroidectomy for cardiac decompensation and angina pectoris and an expression of opinion based on these end-results as to the value of this measure. The relation of blood cholesterol to hyper- and hypothyrodism will be discussed, the value of impedance angle in the diagnosis of hyperthyroidism and the relation of blood iodine and the iodine tolerance test to hyperthyroid conditions.

The clinical factors of hyperparathyroidism as relates, one, to bone decalcification; two osteitis fibrosa cystica; 3, renal calculi, the operative demonstration of parathyroid adenomata and a graphic demonstration of unusual locations of parathyroid bodies.

Fourth Session

Wednesday, October 2, 8:15 P. M.

Meeting Place—Hall of Mirrors, Fourth Floor, Netherland Plaza Hotel.

C. L. Cummer, Cleveland, Past-President, presiding.

1. Annual address of the Retiring President John A. Caldwell, Cincinnati.
2. Presentation of Past President's gavel to Retiring President—C. L. Cummer to John A. Caldwell.
3. Annual address of the President-Elect R. R. Hendershott, Tiffin.
4. Address of Dr. Morris Fishbein, Editor of *The Journal of the American Medical Association.*
5. Informal reception. Music.

Fifth Session

Thursday, October 3, 1:30 P. M.

Meeting Place—Hall of Mirrors, Fourth Floor, Netherland Plaza Hotel.

Paper No. 1—1:30 to 2:00

SOME PRACTICAL CONSIDERATIONS OF HEART DISEASE—by R. Wesley Scott, Cleveland.

A clinical lecture designed for the general practitioner and dealing in a practical way with the diagnosis and management of the common types of heart disease. Lantern slides.

Paper No. 2—2:00 to 2:30

A SURGICAL CAUSERIE—by Leslie L. Bigelow, Columbus.

A surgical causerie—being a desultory discussion of certain commonplace features of surgical practice often disregarded as simple and obvious, but worthy of re-statement and emphasis, not as trivia, but as matters of fundamental and practical importance.

Sixth Session

Thursday, October 3, 3:00 P. M.

Meeting Place—Hall of Mirrors, Fourth Floor, Netherland Plaza Hotel.

Program Presentation by Members of the Faculty of the College of Medicine, University of Cincinnati.

Department of Anatomy:

Paper No. 1—3:00

THE CLINICAL APPLICATIONS OF THE ANATOMY AND PHYSIOLOGY OF THE HYPOTHALMUS—by A. R. Vonderahe.

Department of Surgery:

Paper No. 2—3:20

THE MODERN CONCEPT OF THE TREATMENT OF MALIGNANCIES WITH RADIUM—by Wm. M. Millar.

Department of Medicine:

Paper No. 3—3:40

THE TREATMENT OF ASTHMA WITH BACTERIAL VACCINE. A RESUME OF TEN YEARS' EXPERIENCE—by Stanley E. Dorst.

Paper No. 4—4:00

THE CLINICAL SIGNIFICANCE OF JAUNDICE—by Leon Schiff.

Department of Pediatrics:

Paper No. 5—4:20

FACTORS GOVERNING FLUID THERAPY IN THE TREATMENT OF ENTERITIS—by Glenn E. Cullen (by invitation).

Seventh Session

Thursday, October 3, 7:00 P. M.

Meeting Place—Hall of Mirrors, Fourth Floor, Netherland Plaza Hotel.

BANQUET

A. Graeme Mitchell, M.D., Cincinnati, Toastmaster.

7:50—Address of Welcome—by Hon. Russell Wilson, Mayor of Cincinnati.

8:00—HIGHLIGHTS OF THE FIRST STATE MEDICAL MEETING HELD ONE HUNDRED YEARS AGO—by Jonathan Forman, M.D., Columbus.

8:15 Address: Guest Speaker. "A real surprise is in store for you."

Eighth Session

Friday, October 4, 9:00 A. M.

Meeting Place—Hall of Mirrors, Fourth Floor, Netherland Plaza Hotel.

FINAL SESSION OF THE HOUSE OF DELEGATES—ANNUAL ELECTION

(See detailed program and order of business, Page 682.

Ninth Session

Friday, October 4, 11:00 A. M.

Meeting Place—Hall of Mirrors, Fourth Floor, Netherland Plaza Hotel.

CANCER OF THE CERVIX—by Palmer Findley, Omaha, Nebraska.

About 80 per cent of all cancers of the cervix could have been prevented by the exercise of well-known precautionary measures. Pelvic irradiation therapy will effect a five-year cure in 20 to 25 per cent of all cases; in 50 per cent of early cases and in seven to ten per cent of late cases. Irradiation therapy requires experience and skill comparable to surgery if disappointments and complications are to be minimized. Lantern slides.

HOUSE OF DELEGATES

First Session

Wednesday, October 2, 1:00 P. M.

Meeting Place—Hall of Mirrors, Fourth Floor, Netherland Plaza Hotel.

Presentation of the President of the Ohio State Medical Association by Edward D. King, President of the Academy of Medicine of Cincinnati.

In the chair, John A. Caldwell, President of the Ohio State Medical Association.

House of Delegates Order of Procedure:

1. *Call to order by the President.*
2. *Roll Call.*
3. *Consideration of Minutes of previous meeting.* (Published in *The Journal*, November, 1934).
4. *Reports of Standing Committees:*

   (Reports submitted below, published in full in the October, 1935, *Journal).*

   (a) Public Policy—J. H. J. Upham, Columbus, Chairman.
   (b) Medical Economics—L. L. Bigelow, Columbus, Chairman.
   (c) Publication—Andrews Rogers, Columbus, Chairman.
   (d) Medical Defense—J. E. Tuckerman, Cleveland, Chairman.

(e) Medical Education and Hospitals—Ben R. McClellan, Xenia, Chairman.
(f) Auditing and Appropriations—B. J. Hein, Toledo, Chairman.

5. *Reports of Special Committees:*

(a) Preventive Medicine and Periodic Health Examinations—V. C. Rowland, Cleveland, Chairman.
(b) Military and Veterans' Affairs—Louis Feid, Jr., Cincinnati, Chairman.

6. *Report of Officers:*

(a) Treasurer's report combined with report of Committee on Auditing and Appropriations.
(b) Report of The Council. (Published in October issue, *The Journal*).

7. *Appointment of Committees:*

(a) Committee on Addresses of the President and President-Elect.
(b) Committee on Resolutions.
(c) Committee on Annual Reports.
(d) Committee on Credentials of Delegates.
(e) Committee of Tellers and Judges of Election.

8. *Nomination and Election of Nominating Committee:*

(Nominations from the floor with one representative on the committee to be elected from each councilor district. This committee shall report to the second session, Friday, 9:00 A. M., its recommendations in the form of a ticket, containing nominees for constitutional offices as required under the Constitution. The President will issue instructions to the committee on the constitutional requirements).

9. *Introduction of Resolutions.*

It is necessary that all resolutions introduced in the House of Delegates be referred to the Reference Committee on Resolutions and reported back to the House before any action can be taken. Also resolutions for consideration at this Annual Meeting must be introduced at this session and reported back to the House by the Reference Committee at the Friday morning session. All resolutions must be typewritten and submitted in duplicate.

10. *Miscellaneous Business.*

Second Session

Friday, October 4, 9:00 A. M.

Meeting Place—Hall of Mirrors, Fourth Floor, Netherland Plaza Hotel.

1. *Roll Call.*
2. *Continuance of unfinished business from Wednesday's session of the House of Delegates.*
3. *Annual Election.*

President-Elect. (One year). Nominations from the floor.

4. *Report of Nominating Committee.*

(a) *Election of Members of Council.*
Members of Council are elected for two-year terms, those representing even numbered districts expiring in odd numbered years. To be elected:
Councilor, Second District—Present incumbent, E. M. Huston, Dayton.
Councilor, Fourth District—Present incumbent, B. J. Hein, Toledo.
Councilor, Sixth District—Present incumbent, H. S. Davidson, Akron.
Councilor, Eighth District—Present incumbent, E. R. Brush, Zanesville.
Councilor, Tenth District—Present incumbent, S. J. Goodman, Columbus.
(b) *Election of Delegates and Alternates to the American Medical Association.*
(Three delegates and their respective alternates). (Two years each).
Those whose terms expire at this time are:
J. P. DeWitt, Canton.
G. F. Zinninger, Canton. (Alternate).
C. E. Kiely, Cincinnati.
L. H. Schriver, Cincinnati. (Alternate).
C. W. Waggoner, Toledo.
Charles Lukens, Toledo. (Alternate).

5. *Reports of Reference Committees:*

(a) Committee on Addresses of President and President-Elect.
(b) Committee on Annual Reports.
(c) Committee on Resolutions.

6. *Selection of time and place for Annual Meeting in 1936.*
7. *Miscellaneous Business.*
8. *Installation of Officers for 1935-1936.*
9. *Confirmation by House of Delegates of Committee Appointments announced by the newly-installed President, R. R. Hendershott.*

(a) One member of the Committee on Public Policy. (Three years). (Member whose term expires, C. W. Stone, Cleveland).
(b) One member of the Publication Committee. (Three years). (Member whose term expires, Gilbert Micklethwaite, Portsmouth).
(c) One member of the Committee on Medical Defense. (Three years). (Member whose term expires, F. P. Anzinger, Springfield).
(d) One member of the Committee on Medical Education and Hospitals. (Three years). (Member whose term expires, R. H. Birge, Cleveland).
(e) One member of the Committee on Medical Economics. (Three years). (Member whose term expires, E. O. Smith, Cincinnati, *deceased*).

10. *Unfinished Business.*
11. *Final Adjournment of House of Delegates.*

MEDICAL SECTION

H. W. GAUCHAT, Canton.....Chairman
H. C. KING, Lakewood.....Secretary

First Session

Thursday, October 3, 9:00 A. M.

Meeting Place—Pavilion Caprice, Fourth Floor, Netherland Plaza Hotel.

9:00 to 9:15—Minutes. Business. Selection of Nominating Committee.

Paper No. 1—9:15 to 9:30

THE PRESENT STATUS OF ALLERGIC HEADACHE—by J A. Rudolph, Cleveland.

Allergic headache with the clinical characteristics of migraine has been reported by a number of authors. The commonly used term "migraine" in the main refers to paroxysmal attacks of hemicrania associated with sensory and motor disturbances. These motor and sensory signs and symptoms as well as the crossed hemicrania, gastric and cardiac inhibition and vasomotor changes indicate disease of the cerebral cortex. Thus migraine may be defined as a paroxysmal disease characterized by hemicrania and symptomatic evidence of cortical involvement.

Headaches due to hypersensitiveness cannot be classified as migraine since they do not have cortical features. Symptoms due to allergy must be determined by clinical trial, i.e. relief by avoidance and recurrence on contact or ingestion.

Proper differential diagnosis of headache should be made in order that better results may be had from treatment.

Discussion—9:30 to 9:35—Jonathan Forman, Columbus.

General Discussion—9:35 to 9:45.

Paper No. 2—9:45 to 10:00

FUNCTIONAL HEART DISORDERS—by Franklin Jukes, Akron.

It is of great importance to recognize functional

heart symptoms and to distinguish them from symptoms of organic heart disease. A distressing cardiac neurosis is easily implanted when such errors in diagnosis are made. Subjective symptoms of palpitation, heart-consciousness, shortness of breath and precordial pain may all be present in the absence of an organic lesion. Functional heart murmurs should be distinguished from organic murmurs. Many arrhythmias are of functional origin. Neuro-circulatory asthenia is reviewed as a clinical syndrome. Treatment of the patient must include adjustment of his habits and routine of living together with adequate psycho-therapy. Therapy in general is directed at the nervous system while certain of the arrhythmias respond to specific medication.

Discussion—10:00 to 10:05—John P. Anderson, Cleveland.

General Discussion—10:05 to 10:15.

Paper No. 3—10:15 to 10:30

THE DIAGNOSIS AND TREATMENT OF PULMONARY TUMORS—by Samuel A. Brown, Cincinnati.

This paper will be confined to the X-ray diagnosis and treatment of pulmonary tumors. The differential diagnosis from cardio-vascular and other pulmonary affections will be fully discussed. The differential diagnosis between benign and malignant new growths of the thoracic structures will receive due consideration. The X-ray treatment of pulmonary tumors during the past 16 years and the results obtained will be presented in more or less detail.
(Scientific Exhibit.)

Discussion—10:30 to 10:35—William M. Doughty, Cincinnati.

General Discussion—10:35 to 10:45.

Paper No. 4—10:45 to 11:00

CONSTITUTIONAL OR NON-GASTRIC FACTORS IN THE PEPTIC ULCER SYNDROME—by Louis A. Levison, Toledo.

A consideration and review of the neurogenic theories of the cause of peptic ulcers. Constitutional states are considered. Careful study of the history of peptic ulcer patients will show many symptoms usually found in patients having nervous disturbances and often having autonomic imbalance. Vasomotor circulatory changes not uncommonly are associated with the gastric syndrome. This relationship has a definite importance in the management of these patients, as it may be of primary importance in the treatment.

Discussion—11:00 to 11:05—V. C. Rowland, Cleveland.

General Discussion—11:05 to 11:15.

Paper No. 5—11:15 to 11:30

ACUTE MONOCYTIC (HISTIOCYTIC) LEUKEMIA—by Thomas L. Ramsey and Reynold A. Tank, Toledo.

The conception is still general that but two types of leukemia exist; myelogenous, arising from the bone marrow, and lymphatic, arising from the lymphoid tissue.
That there is a third form of leukemia, arising from the reticulo-endothelial (histiocytic) cell system and characterized hematologically by an extreme degree of monocytosis and histiocytosis, is not as yet well recognized.
An acute irreversable proliferation of that system gives the clinical picture and a comparison of reported cases indicates a similarity that seems to emphasize the existence of a clear cut entity, monocytic leukemia.
A case report and autopsy findings are submitted. Lantern slides.

Discussion—11:30 to 11:35 — Charles A. Doan, Columbus.

General Discussion—11:35 to 11:45.

Second Session

Friday, October 4, 2:00 P. M.

Meeting Place—Pavilion Caprice, Fourth Floor, Netherland Plaza Hotel.

2:00 to 2:15—Business. Election of Officers.

Paper No. 1—2:15 to 2:30

END-RESULTS AND THERAPY OF LUNG ABSCESS—by S. O. Freedlander, Cleveland.

This report is based on the observation of over two hundred cases of lung abscess during a period of eight years. Putrid lung abscess is a definite clinical entity initiated by pathogenic anaerobes of the type inhabiting the upper respiratory tract. Which of these organisms is responsible, has not been proved.
Aspiration is the most important single etiological factor, although there is much variation in the mode of onset and the course of the disease.
Methods of treatment are discussed with the emphasis upon drainage by conservative and radical methods. Arsenical therapy and compressive measures have proved of little value. The prognosis depends largely upon the mode of onset and the duration of the disease before treatment. Lantern slides.

Discussion—2:30 to 2:35—Carl R. Steinke, Akron.

General Discussion—2:35 to 2:45.

Paper No. 2—2:45 to 3:00

GASTRITIS, DUODENITIS AND THEIR RELATION TO PEPTIC ULCER—by Walter Stix, Cincinnati.

One hundred years ago, chronic gastritis was regarded as a very frequent ailment. Virchow was one of the first to call attention to the fact that what were taken to be inflammatory lesions in the stomach were in fact autolytic changes after death. The introduction of the stomach tube by Kussmaul, and the teachings of V. Leube, made the diagnosis of chronic gastritis unpopular. Since that time it has been considered a relatively infrequent condition.
In the last ten years, due to new methods of examination, we are coming back to the old view and recognize that chronic gastritis is one of the most frequent ailments we have. It is present in practically every case of peptic ulcer and cancer of the stomach. Its casual relation to peptic ulcer has evoked a tremendous controversy in the medical world. This view is of more than theoretical interest as it radically changes our previous ideas in regards to treatment of peptic ulcers.

Discussion—3:00 to 3:05—Leon Schiff, Cincinnati.

General Discussion—3:05 to 3:15.

Paper No. 3—3:15 to 3:30

CAUSES FOR FAILURE IN THE TREATMENT OF DIABETES—by R. W. Finley, Cleveland.

The increasing understanding of the possibilities of treatment in diabetes is somewhat changing our ideas of the end-results attainable. As a result ideas of success and failure are being modified. Old, stubborn problems are re-asserting themselves with new insistence because they can be more successfully dealt with. Added causes for failure are being recognized, and the advisability of treatment being conducted by the patient's own physician in the patient's own home rather than in the hospital is increasing. Lantern slides.

Discussion—3:30 to 3:35—A. F. Kuhl, Dayton.

General Discussion—3:35 to 3:45.

Paper No. 4—3:45 to 4:00

DIABETIC COMA—by T. P. Sharkey, Dayton.

Through the courtesy of Dr. E. P. Joslin and his associates the data on 276 cases of "Diabetic Coma" are presented. The various clinical and laboratory features are discussed. Treatment is emphasized. Lantern slides.

Discussion—4:00 to 4:05—Cecil Striker, Cincinnati.

General Discussion—4:05 to 4:15.

Paper No. 5—4:15 to 4:30

CARDIAC ASTHMA—by A. Carlton Ernstene and Richard S. Knowlton (by invitation), Cleveland.

Cardiac asthma usually is the result of sudden failure of the left ventricle with consequent acute pulmonary congestion. In a small group of patients with uncomplicated mitral stenosis, however, similar attacks are precipitated by increased demands on the heart and are due to the fact that the mechanical obstruction of the stenosed mitral valve hinders the blood from passing into the left ventricle as rapidly as the right ventricle supplies the pulmonary circulation. In a series of 36 consecutive cases of cardiac astbma, the attacks were due to the first of these mechanisms in 29, and to the second in 3, while in 4 cases both mechanisms may have played a part. The findings in these three groups of patients have been compared, and treatment and prognosis will be discussed. Lantern slides.

Discussion—4:30 to 4:35—Hubert C. King, Lakewood.

General Discussion—4:35 to 4:45.

SURGICAL SECTION

VERNE A. DODD, Columbus.....Chairman
MAX M. ZINNINGER, Cincinnati.....Secretary

First Session

Thursday, October 3, 9:00 A. M.

Meeting Place—Hall of Mirrors, Fourth Floor, Netherland Plaza Hotel.

9:00 to 9:15—Minutes. Business. Selection of Nominating Committee.

Paper No. 1—9:15 to 9:30

THE SURGICAL MANAGEMENT OF INTRACRANIAL MENINGIOMAS—by Wm. James Gardner, Cleveland.

This paper represents the author's experience with these lesions during the last five years. The symptoms, of course, depend upon the location of the growth. Favorite sites are along the sagittal sinus, the olfactory groove, the tuberculum sellae, and the sphenoidal ridge. The method of surgical attack is dependent upon the location. Lantern slides.

Discussion—9:30 to 9:35—Roy D. Arn, Dayton.

General Discussion—9:35 to 9:45.

Paper No. 2—9:45 to 10:00

THE SURGICAL TREATMENT OF INTESTINAL OBSTRUCTION—by Robert C. Austin, Dayton.

Seventy-five per cent of intestinal obstructions follow surgical procedures. Knowledge of the chemical and physiological factors have added but little to mortality reduction. The diagnosis and surgery in appendicitis before perforation, limitation of and intelligent use of drains, gentle surgical handling of the contents of the peritoneal cavity which invites the use of a relaxing anesthesia, peritonization of raw areas and use of the great omental apron in pelvic surgery are preventive factors.

In the treatment of obstructions, the use of the enterostomy per se has been a fallacious teacbing. The relief of cause is essential. Careful appraisal of laboratory data and clinical signs to obviate delay, employment of spinal anesthesia, and intelligent selection of the proper surgical procedure will appreciably reduce mortality.

Discussion—10:00 to 10:05—Eslie Asbury, Cincinnati.

General Discussion—10:05 to 10:15.

Paper No. 3—10:15 to 10:30

EXTRA-ARTICULAR DISABILITIES OF THE SHOULDER JOINT—by Rudolph S. Reich, Cleveland.

Subacromial and subdeltoid bursitis may clear up with proper treatment or continue as periarthritis with adhesions. These conditions are too often termed neuritis. Rupture of the supraspinatous tendon must always be borne in mind, especially in individuals past forty. Differential diagnosis and treatment are discussed in detail. Lantern slides.

Discussion—10:30 to 10:35—Albert H. Freiberg, Cincinnati.

General Discussion—10:35 to 10:45.

Paper No. 4—10:45 to 11:00

NEPHROPTOSIS—by Parke G. Smith and Gordon F. McKim, Cincinnati.

A discussion of the basic mechanical faults resulting from nephroptosis and an explanation of the manner in which they produce the varied clinical manifestations of this condition. A motion picture of the surgical technic employed for the correction of this situation. Motion pictures.

Discussion—11:00 to 11:05—Wm. N. Taylor, Columbus.

General Discussion—11:05 to 11:15.

Paper No. 5—11:15 to 11:30

DIAPHRAGMATIC HERNIA—by B. N. Carter, Cincinnati.

Several cases of diaphragmatic hernia will be shown and will be used to illustrate the etiology, classification, diagnosis and treatment of hernia through the diaphragm. Lantern slides.

Discussion—11:30 to 11:35—Carl R. Steinke, Akron.

General Discussion—11:35 to 11:45.

Second Session

Friday, October 4, 2:00 P. M.

Meeting Place—Hall of Mirrors, Fourth Floor, Netherland Plaza Hotel.

2:00 to 2:15—Business. Election of Officers.

Paper No. 1—2:15 to 2:30

A CRITICAL ANALYSIS OF THE DIAGNOSIS AND SURGICAL TREATMENT OF THYROID CONDITIONS—by Norris W. Gillette, Toledo.

Diagnosis of thyrotoxicosis is difficult in small and incipient goitres. In addition to clinical opinion the B.M.R., the impedance angle test, the blood iodine

test and the sphygmatonograph give valuable assistance in the diagnosis. A large percentage of cases of Grave's constitution of Warthin are being operated each year, probably due to increased medical treatment. The size of the gland should not influence the decision as to operation. Remarks on postoperative treatment with a valuation of the denervation of the adrenals and partial adrenalectomy in reference to postoperative thyrotoxicosis.

Discussion—2:30 to 2:35—E. R. Arn, Dayton.

General Discussion—2:35 to 2:45.

Paper No. 2—2:45 to 3:00

INDICATIONS FOR SPLENECTOMY—by Ralph W. Good, Cincinnati.

Exclusive of removal of the spleen for the control of hemorrhage from traumatic rupture, splenectomy is a recognized procedure for the arrest of certain blood dyscrasias, especially splenic anemia, thrombocytopenic purpura, and hemolytic jaundice. All other splenomegalias are removed for size and weight alone. The differential diagnosis will be discussed and clinical examples will be presented by lantern slides.

Discussion—3:00 to 3:05—Joseph N. Ganim, Cincinnati.

General Discussion—3:05 to 3:15.

Paper No. 3—3:15 to 3:30

THE ESTABLISHMENT OF A NEW BLOOD SUPPLY TO THE HEART BY OPERATION—by Claude S. Beck, Cleveland.

Experimentally a collateral vascular bed was provided for the heart. It supplied the myocardium with blood. In these experiments we were able to ligate both coronary arteries close to the aorta. We concluded from these experiments that the heart was given a new blood supply. We also showed experimentally that a heart with a collateral vascular bed could withstand ligation of the right coronary artery. In this respect the collateral vascular bed acts as a prophylaxis against the ravages of right coronary occlusion. A coronary vascular bed was given to several patients with coronary disease. Lantern slides.

Discussion—3:30 to 3:35—Harold Feil, Cleveland.

General Discussion—3:35 to 3:45.

Paper No. 4—3:45 to 4:00

SURGICAL PROCEDURES FOR THE RELIEF OF PAIN—by H. E. LeFever, Columbus.

I. Central Nervous System
Indications for (a) Cordotomy, (b) Myelotomy of the posterior commissure, (c) Intra-thecal injection of absolute alcohol.
II. Sympathetic System.
Various diseases, diagnosis and methods of evaluation in which surgical attack upon the sympathetic nervous system may relieve pain.
III. Peripheral Nerves.
Various lesions in which peripheral section is indicated for the relief of pain.

Discussion—4:00 to 4:05—George M. Curtis, Columbus.

General Discussion—4:05 to 4:15.

Paper No. 5—4:15 to 4:30

ACUTE APPENDICITIS WITH PERFORATION—by A. T. Bowers, Dayton.

A review of approximately 300 cases of ruptured appendix with classification according to the surgical observations. Treatment in these cases was guided by the operative findings. The operative mortality was quite low in generalized peritonitis when the abdomen was flushed with large amounts of saline and closed without drainage. The postoperative treatment of complications following ruptured appendix is discussed at considerable length. Lantern slides.

Discussion—4:30 to 4:35—Frank S. Gibson, Cleveland.

General Discussion—4:35 to 4:45.

OBSTETRICS AND GYNECOLOGY

J. K. HOERNER, Dayton.....Chairman
JAMES M. PIERCE, Cincinnati.....Secretary

First Session

Thursday, October 3, 9:00 A. M.

Meeting Place—Parlors A, B, C and D, Fourth Floor, Netherland Plaza Hotel.

9:00 to 9:15—Minutes. Business. Selection of Nominating Committee.

Paper No. 1—9:15 to 9:30

LAPAROTRACHELOTOMIES: A CLINICAL APPRAISAL—by S. B. Conger, Akron.

A brief history of the development of the low Cesarean section followed by a discussion of the indications and contra-indications for its use. From an analysis of fifty cases the author concludes that because of its greater safety laparotrachelotomy will soon replace the classical operation. Lantern slides.

Discussion—9:30 to 9:35—A. J. Skeel, Cleveland.

General Discussion—9:35 to 9:45.

Paper No. 2—9:45 to 10:00

THE USE OF IODIZED OIL IN GYNECOLOGY—by J. L. Reycraft, Cleveland.

A review of the subject of uretero-salpingography, together with a report of a series of cases from Lakeside Hospital. The therapeutic effect of iodized oil is emphasized as well as its use in the diagnosis of pelvic pathology. Lantern slides.

Discussion—10:00 to 10:05—George Lyford, Cincinnati.

General Discussion—10:05 to 10:15.

Paper No. 3—10:15 to 10:30

THE TREATMENT OF ABORTIONS—by Joseph D. Heiman and Jean Stevenson (by invitation), Cincinnati.

An analysis of three hundred consecutive cases of abortion is presented. The results of non-interference, sponge forcep evacuation, and curettment are compared. Lantern slides.

Discussion—10:30 to 10:35—V. B. Roberts, Cincinnati.

General Discussion—10:35 to 10:45.

Paper No. 4—10:45 to 11:00

OBSERVATIONS ON OVARIAN AND PITUITARY ENDOCRINOPATHIES WITH SPECIAL REFERENCE TO BASOPHIL ADENOMA—by Marion Douglass, Cleveland.

General summary of the sequence of events from which has developed (Fraenkel to Hartman) our knowledge of endocrinology, is briefly discussed. The experiments of Hartman, the development of the Zondek Ascheim test, the status of follicular hormone

therapy and the role of luteinizing hormone of the pituitary and progestational effect of corpus luteum are considered.

Mention is made of the newer tumors with an internal secretion, of the granulosa cell and arrhenoblastoma type. Pituitary basophilism with a report of the three cases is discussed as a syndrome. Lantern slides.

Discussion—11:00 to 11:05—Edwin J. Stedem, Columbus.

General Discussion—11:05 to 11:15.

Paper No. 5—11:15 to 11:30

A DISCUSSION OF MATERNAL DEATH RATE—by Scott C. Runnels, Cleveland.

A study of the causes of maternal morbidity and mortality in the United States, New York City, Philadelphia and Cleveland are compared, and the Cleveland deaths analyzed. This review of maternal mortality statistics emphasizes phases of the subject that are as yet unstudied and shows that the first step in the improvement of obstetrics is a realization of the number of obstetrical failures and an analysis of their causes. Lantern slides.

Discussion—11:30 to 11:35—Walter Brand, Toledo.

General Discussion—11:35 to 11:45.

Second Session

Friday, October 4, 2:00 P. M.

Meeting Place—Parlors A, B, C and D, Fourth Floor, Netherland Plaza Hotel.

2:00 to 2:15—Business. Election of Officers.

Paper No. 1—2:15 to 2:30

A STUDY OF POST-DELIVERY DEATHS CAUSED BY EMBOLISM—by C. T. Hemmings, Cleveland.

Post-delivery embolism is responsible for a rapidly increasing number of tragic, sudden deaths. Deliveries and postdelivery procedures which implicate the pampiniform and hemorrhoidal plexuses give rise to thrombosis which predisposed to embolism.

Trauma, infection and venous stasis are chief etiological factors.

Obesity, hypotension, toxemia, anemia and fibroids predispose to venous stasis. Treatment is mainly prophylactic in character. Better aseptic technic, diminution of blood loss at time of delivery, limitation of trauma, transfusions for anemia, and the combating of circulatory stasis are recommended.

Our statistics have been helpful in clarifying etiology and improving prophylactic measures which combat thrombosis. Lantern slides.

Discussion—2:30 to 2:35—F. W. Milward, Lakewood.

General Discussion—2:35 to 2:45.

Paper No. 2—2:45 to 3:00

THE SIGNIFICANCE OF POSTPARTUM CARE OF THE UTERINE CERVIX—by J. Isfred Hofbauer, Cincinnati.

While the fundamental principles of prenatal supervision are well-established the therapeutic problems peculiar to postpartum care of the generative tract still represent subjects of ardent discussion. The advisability of restoration of the uterine cervix has more and more been recognized in recent years. Whether to take any action, in this respect, immediately after delivery or at a remote term, demands discussion.

The true significance of proper care of the uterine cervix as a preventive measure concerning certain sequelae of labor, such as leucorrhea, pelvic pain and backache, and finally regarding uterine carcinoma is discussed and lantern slides shown.

Discussion — 3:00 to 3:05—J. L. Bubis, Cleveland.

General Discussion—3:05 to 3:15.

Paper No. 3—3:15 to 3:30

HYSTERECTOMY, A CLINICAL AND STATISTICAL STUDY—by R. L. Faulkner, Cleveland.

This paper will embrace a consideration of routine surgical hysterectomy, including symptomatology, indications for operation, the pathological conditions present, types of operation performed, and finally, postoperative complications, morbidity and mortality. The study is based on operations performed during the past five years at the University Hospital and is a continuation of the study of 1851 cases previously reported. Lantern slides.

Discussion—3:30 to 3:35—Wm. D. Fullerton, Cleveland.

General Discussion—3:35 to 3:45.

Paper No. 4—3:45 to 4:00

THE SIGNIFICANCE OF THE MID-PELVIC TRAPEZOID IN LABOR—by John Gardiner, Toledo.

The mid-pelvic trapezoid lies in the plane of the ischial spines parallel to the superior strait. Its longest side, the left, is the distance between the left ischial spine and a point on the right side of the pelvis at the junction of the ascending ramus of the ischium and of the descending ramus of the pubis (the left ischial-ramic diameter). The anterior side is the distance between the point at the junction of the rami mentioned above and the right ischial spine: the posterior side is the distance between the left ischial spine and the right edge of the sacrum. The shortest or right side of the trapezoid is the distance between the right edge of the sacrum and the right ischial spine.

In the O.L.A. position of the head, the interparietal diameter passes through the ischial-ramic diameter i.e. the left or largest end of the mid-pelvic trapezoid.

In an O.R.P. position the large transverse or interparietal diameter of the fetal head lies in the small end of the mid-pelvic trapezoid which accounts for the difficult labor in this position.

Lantern slides.

Discussion—4:00 to 4:05—Wm. D. Porter, Cincinnati.

General Discussion—4:05 to 4:15.

PEDIATRICS SECTION

I. H. KASS, Toledo.....Chairman
HUGH FOSTER, Toledo.....Secretary

First Session

Thursday, October 3, 9:00 A. M.

Meeting Place—Parlors E and F, Fourth Floor, Netherland Plaza Hotel.

9:00 to 9:15—Minutes. Business. Selection of Nominating Committee.

Paper No. 1—9:15 to 9:30

PREVENTIVE PROCEDURES IN INFANCY—by T. K. Selkirk and J. V. Greenebaum, Cincinnati.

Many books and pamphlets on the care of infants are written for mothers. The material written for physicians is scattered throughout text books and medical periodicals but is not well organized for practical use. An outline of preventive procedures such as innoculations, selection of food, clothing, hygiene, etc., during the first 2 years of life would assist physicians in their supervision of infants. Lantern slides.

Discussion—9:30 to 9:35—John A. Toomey, Cleveland.

General Discussion—9:35 to 9:45.

Paper No. 2—9:45 to 10:00

FUSOSPIROCHAETAL INFECTION OF LUNG IN CHILDREN—by W. B. Taggart, Dayton.

A case of fuso-spirochaetal infection of one lung in an infant fifteen months of age. There was an extensive gingivitis and adenitis associated with the lung infection.

Slides showing progressive lung changes will be shown.

A consideration of the medical and surgical aspects of treatment of this condition is presented. Lantern slides.

Discussion—10:00 to 10:05—H. S. Reichle, Cleveland.

General Discussion—10:05 to 10:15.

Paper No. 3—10:15 to 10:45

CHRONIC ULCERATIVE COLITIS IN CHILDHOOD—by H. F. Helmholz, Rochester, Guest Speaker.

Dr. Helmholz's paper will be a review of all the cases of chronic ulcerative colitis in childhood seen at the Mayo Clinic during the past fifteen years. Lantern slides.

Discussion—10:45 to 10:50—A. Graeme Mitchell, Cincinnati.

General Discussion—10:50 to 11:00.

Paper No. 4—11:00 to 11:15

THE RED BLOOD CELLS IN NUTRITIONAL ANEMIA OF INFANTS—by George M. Guest, Cincinnati.

Quantitative studies of changes in the size and hemoglobin content of the erythrocytes of normal infants, followed from birth through the first years, are instructive in showing the manner in which the blood picture of nutritional anemia develops. Such studies, moreover, afford diagnostic aid and a means of control over therapy. In seemingly normal infants, careful examination of the blood reveals a higher incidence of nutritional anemia than is generally realized, and this problem appears to be of major importance in preventive pediatrics.

Discussion—11:15 to 11:20—Russell L. Haden, Cleveland.

General Discussion—11:20 to 11:30.

Paper No. 5—11:30 to 11:45

THE RELATION OF THE INSULIN REQUIREMENT TO THE GROWTH AND WEIGHT INCREASE IN THE DIABETIC CHILD—by Henry J. John, Cleveland.

Review of medical literature brings out the fact that in diabetic children the insulin requirement is increased during their greatest growth and weight increase. This seems logical. There are of course many other factors entering into the problem which have to be evaluated. A close study of my own series of diabetic children over a period of years shows that the above statement does not hold. Some show a definite increase in the insulin with the period of their greatest growth while others shows a decrease in the insulin requirement during such a period and others still show neither of the above. Lantern slides to illustrate the above.

Discussion—11:45 to 11:50—Cecil Striker, Cincinnati.

General Discussion—11:50 to 12:00.

Second Session

Friday, October 4, 2:00 P. M.

Meeting Place—Parlors E and F, Fourth Floor, Netherland Plaza Hotel.

2:00 to 2:15—Business. Election of Officers.

Paper No. 1—2:15 to 2:30

THERAPEUTIC ASPECTS OF INFANTILE ECZEMA—by Leon H. Dembo, Cleveland.

A consideration of the common methods in vogue for the treatment of the eczemas of infancy and childhood, with special emphasis on some of the newer forms of therapy more recently applied.

A brief review of the literature depicting the results of various forms of treatment is included, with an analysis of between 200 and 250 cases from dispensary and private practice. The therapeutic approach is considered from the standpoint of commonly accepted etiological backgrounds, namely: allergic, dietetic, dermatologic. Recent, new theories are discussed in relation to etiology and treatment. Results of treatment are summarized, with a suggested outline of practical therapy. Lantern slides.

Discussion—2:30 to 2:35—J. Edgar Fisher, Cleveland.

General Discussion—2:35 to 2:45.

Paper No. 2—2:45 to 3:00

NASAL MANIFESTATIONS OF ALLERGY IN INFANCY AND CHILDHOOD—by Karl D. Figley, Toledo.

Frequency of nasal allergy in early life. Clinical manifestations, perennial or seasonal allergic rhinitis. Associated allergic manifestations. Diagnosis by history, rhinoscopic examination and skin tests. Treatment. Illustrative case reports. Lantern slides.

Discussion—3:00 to 3:05—Karl D. Way, Akron.

General Discussion—3:05 to 3:15.

Paper No. 3—3:15 to 3:30

STRONGYLOIDES STERCORALIS WITH REPORT OF TWO CASES—by E. A. Wagner, Cincinnati.

Strongyloides Stercoralis a parasitic infection not common in this region.

Brief description of the parasite and its life cycle. Lantern slides.

Symptoms of infection.

Blood findings. The marked eosinophilia, as high as 50 per cent in one of the cases.

Stool examination disclosing the larva.

The difficulties experienced in treatment.

The use of gentian violet in enteric coated pills.

Report of two cases. Lantern slides.

Discussion—3:30 to 3:35—Merlin Cooper, Cincinnati.

General Discussion—3:35 to 3:45.

Paper No. 4—3:45 to 4:00

A SERIES OF RAMSTEDT OPERATIONS FOR PYLORIC STENOSIS IN INFANTS—by H. B. Meader, Toledo.

The minimum and maximum age incidence is noted with tbe weight of the infant at the time of operation compared to birth weight. The diagnosis is discussed, with particular attention being paid to regurgitation of feedings, visible anti-peristalsis, X-ray evidence and palpation of mass.

The method of preoperative treatement is important. A description of the surgical technic and the operative procedure which is done under local anesthesia. The postoperative treatment is important—particular care being paid by the pediatrician in fractional feedings in the beginning.

The later status of these babies is that of the normal child.

Discussion—4:00 to 4:05—S. D. Giffen, Toledo.

General Discussion—4:05 to 4:15.

Paper No. 5—4:15 to 4:30

THE NEUROLOGIC COMPLICATIONS OF ACUTE AND CHRONIC MASTOIDITIS—by Carl H. Bayha, Toledo.

These complications include in their order of frequency—lateral sinus thrombosis, cerebro-spinal men-

ingitis, serous meningitis, including Gradinego's syndrome, brain abscess.

Illustrative cases of each of these conditions will be presented with remarks on the diagnosis and treatment. Lantern slides.

Discussion—4:30 to 4:35—Edward W. Harris, Columbus.

General Discussion—4:35 to 4:45.

EYE, EAR, NOSE AND THROAT

H. V. DUTROW, Dayton.....Chairman
O. J. WALKER, Youngstown.....Secretary

First Session

Thursday, October 3, 9:00 A. M.

Meeting Place—Foyer of Pavilion Caprice, Fourth Floor, Netherland Plaza Hotel.

9:00 to 9:15—Minutes. Business. Selection of Nominating Committee. Presentation of instruments.

Paper No. 1—9:15 to 9:30

UNUSUAL CASES OF FOREIGN BODIES IN THE FOOD AND AIR PASSAGES—by Horace E. Mitchell, Lakewood.

Small toy aeroplane in esophagus with large thymus. Lumps of coal in bronchi. Tack in left main stem bronchus treated for allergy. Two foreign bodies in left main stem bronchus with congenital absence of the right lung.

Discussion—9:30 to 9:35—Hugh G. Beatty, Columbus.

General Discussion—9:35 to 9:45.

Paper No. 2—9:45 to 10:00

BLOOD STREAM INFECTIONS IN OTOLARYNGOLOGY—by F. F. Piercy, Youngstown.

Blood stream infections which interest the otolaryngologist usually come from the tonsils, sinuses or mastoids. The germs or toxins are taken up by the capillaries, the lymphatics or pass directly through to the tissues. The germs or their toxins cause many changes in the blood, causing it to act as a germ destroyer, or as a neutralizer to the toxins and bring on immunity. Many different substances have been injected directly into the blood stream to assist nature to fight the invaders, but only one seems to do good—blood transfusion. If the donor has had the same infection, the blood is more effective and may act like a specific.

Discussion—10:00 to 10:05—Fred W. Dixon, Cleveland.

General Discussion—10:05 to 10:15.

Paper No. 3—10:15 to 10:30

SOME CLINICAL OBSERVATIONS ON THE MAXILLARY ANTRUM WITH REPORT OF CASE—by Edward D. King, Cincinnati.

Considerable time has been spent in a study of the antrum by means of X-ray and iodized oil before and after operation. The results of this study will be shown by means of slides.

Further studies have been made of the function of the antrum mucosa in cases in which the intra-nasal window has been made. The results of these studies will be demonstrated. Lantern slides.

Discussion—10:30 to 10:35—John D. Fouts, Dayton.

General Discussion—10:35 to 10:45.

Paper No. 4—10:45 to 11:00

THE IONIZATION TREATMENT FOR HAYFEVER AND HYPERESTHETIC RHINITIS—by Ben L. Bryant, Cincinnati.

The technique of treatment of hayfever and vasomotor rhinitis by ionization of the nasal mucous membranes as first described by Dr. Harold L. Warwick, of Ft. Worth, Texas, is presented. The results in a series of cases so treated are analyzed and suggestions are made as to selection of cases, preparation of the patient, and measures to avoid possible reactions to the treatment.

Discussion—11:00 to 11:05—Victor W. Fischbach, Cincinnati.

General Discussion—11:05 to 11:15.

Paper No. 5—11:15 to 11:45

HEADACHE OF NASAL ORIGIN—by Wm. E. Sauer, St. Louis, Guest Speaker.

This paper briefly mentions the early observations of the disorders of the nose and their relation to headache, with a review of the nerve supply of the mucous membrane of the nose and the accessory sinuses. A discussion of the mechanism of headache with an explanation of the nervous pathways by which pain, remote from the seat of infection in the nose or sinuses, may be traced to the various regions of the body to which the pain may be referred. The difficulties of the diagnosis and the importance of the cooperation of the internist, neurologist, occulist, allergist, and endocrinologist is fully emphasized. Case histories illustrating the various types of nasal headache and neuralgia and the results obtained by correcting what seemed to be minor or trivial changes in the nose. Lantern slides.

Discussion—11:45 to 11:50—Harris H. Vail, Cincinnati.

General Discussion—11:50 to 12:00.

Second Session

Friday, October 4, 2:00 P. M.

Meeting Place—Foyer of Pavilion Caprice, Fourth Floor, Netherland Plaza Hotel.

2:00 to 2:15—Business. Election of Officers.

Paper No. 1—2:15 to 2:45

THE PRACTICAL USE OF BACTERIOLOGY BY THE OPHTHALMOLOGIST—by Sanford R. Gifford, Chicago, Guest Speaker.

Technique of obtaining material from the ocular structures. Reasons why the ophthalmologist should do this himself. Value of epithelial scrapings. The common conjunctival saprophytes. Pathogenic organisms peculiar to the eye. The Morax-Axenfeld bacillus and related organisms. The inclusion bodies, trachoma, inclusion blenorrhoea and swimming-pool conjunctivitis. Gonococcal infections. Other gram-negative cocci which may cause conjunctivitis. Lantern slides.

Discussion—2:45 to 2:50—A. G. Farmer, Dayton.

General Discussion—2:50 to 3:00.

Paper No. 2—3:00 to 3:15

PRACTICAL MANAGEMENT OF THE MYOPIAS—by Ivor G. Clark, Columbus.

The literature of myopia at the present time is in a state of confusion. This is probably due to the fact that the condition does not lend itself readily to experimental approach. The subject commonly calls for extensive full time research. For the present a tentative classification may be advanced for clinical purposes. The study of heredity and a critical analysis of monocular myopia offers the best approach to

progress in the study of the management of myopia.
Analysis of the author's series.
More recent conception of the treatment of myopia.
The value of the Special Privilege Schools in controlling the condition. Lantern slides.

Discussion—3:15 to 3:20—A. D. Ruedeman, Cleveland.

General Discussion—3:20 to 3:30.

Paper No. 3—3:30 to 3:45

THE RELATIONSHIP OF EYE DEFECTS TO SCHOOL FAILURES—by Geo. L. King, Jr., and Dorothea Keplinger, M.A. (by invitation), Alliance.

A study of failure children in the public schools is reported wtih a view to correlating the amount of eye defect with the number of failures. An arbitrary method is adopted for measuring the total defect for the sake of comparison and tables are presented showing the defects. A control group of passing children has been examined in exactly the same manner and the results tabulated for comparison with the failure group. Careful psychological studies have been carried out to avoid the influence of mental defects on the results obtained. Lantern slides.

Discussion—3:45 to 3:50—S. H. Monson, Cleveland.

General Discussion—3:50 to 4:00.

Paper No. 4—4:00 to 4:15

OBSERVATIONS ON CATARACT EXTRACTION—by R. S. Binkley, Dayton.

The success or failure of cataract operation can be judged by the mental attitude, physical comfort of your patient before operation.
The entrance and exit of the point and parallel position of the blade in conjunctival or corneal flap determine the rapidity of closure of the incision.
The advantage of the conjunctival over corneal flap, with Elschnig intra-capsular extraction presents the ideal operation for the casual operator.
Comfort and relaxation for post operative treatment by raising head of bed thirty degrees and subdued light.

Discussion—4:15 to 4:20—J. W. Millette, Dayton.

General Discussion—4:20 to 4:30.

NERVOUS AND MENTAL DISEASES

C. C. KIRK, Orient.....Chairman
F. C. WAGENHALS, Columbus.....Secretary

Thursday, October 3, 9:00 A. M.

Meeting Place—Parlor G, Fourth Floor, Netherland Plaza Hotel.

9:00 to 9:15—Minutes. Business. Selection of Nominating Committee.

Paper No. 1—9:15 to 9:30

AKINESIA ALGERA—by Louis Miller, Toledo.

1. Its rarity (I have made the diagnosis only twice in 30 years.)
2. Its psychic nature.
3. Being easily overlooked in differential diagnosis.
4. Medico-legal importance. It may be mistaken for either an organic malady, or malingering.
5. A case report.

Discussion—9:30 to 9:35—Roy D. Arn, Dayton.

General Discussion—9:35 to 9:45.

Paper No. 2—9:45 to 10:00

VALUE OF MALARIA TREATMENT IN CONGENITAL SYPHILIS—by Robert A. Kidd, Jr., Columbus.

In our study of about one hundred cases of congenital syphilis treated by malaria, we have found clinically as well as from a serological standpoint that they have made an unusual recovery, that antisyphilitic treatment has an increased efficiency after malaria. Children of all ages being treated with no deaths in the series.

Discussion—10:00 to 10:05—D. A. Johnston, Cincinnati.

General Discussion—10:05 to 10:15.

Paper No. 3—10:15 to 10:30

NEURO-MYELITIS-OPTICA—by Charles E. Kiely, Cincinnati.

A syndrome of optic neuritis cervical myelitis, and peripheral neuritis has been designated by many names of which "Neuro-myelitis-optica" is the most descriptive. The earliest description is that of Clifford Albutt in the Lancet (1870). Three cases are reported. The relation to Schilders disease and acute multiple sclerosis are discussed.

Discussion—10:30 to 10:35—Clarence King and Horace Reid, Cincinnati.

General Discussion—10:35 to 10:45.

Paper No. 4—10:45 to 11:00

SOME UNDESIRABLE EFFECTS FROM THE PROLONGED USE OF VARIOUS BARBITURATES—by Charles W. Stone, Cleveland.

The clinical effects of acute toxic poisoning with barbiturates is fairly well understood. Less well recognized are the results sometimes encountered in the chronic toxic activity produced by these compounds. Some of these effects are illustrated in clinical observations of the physical and particularly, of the mental status of patients.

Discussion—11:00 to 11:05—Franklin C. Wagenhals, Columbus.

General Discussion—11:05 to 11:15.

Paper No. 5—11:15 to 11:30

MENOPAUSE SYNDROME—by Carl W. Sawyer, Marion.

Different phases of nervous and mental manifestations with general bodily disturbances of other types that appear during the menopause.
The different expressions of menopause syndrome will be taken up and various conditions which it is associated with will be discussed.

Discussion—11:30 to 11:35—Isabel Bradley, Columbus.

General Discussion—11:35 to 11:45.

11:45 Business. Election of Officers.

PUBLIC HEALTH AND PREVENTIVE MEDICINE

J. DEAN BOYLAN, Milford Center.....Chairman
EMERY R. HAYHURST, Columbus.....Secretary

Friday, October 4, 2:00 P. M.

Meeting Place—Parlor G, Fourth Floor, Netherland Plaza Hotel.

2:00 to 2:15—Minutes. Business. Selection of Nominating Committee.

Paper No. 1—2:15 to 2:30

THE RELATION OF THE PRACTITIONER TO THE PUBLIC HEALTH DEPARTMENT—by F. M. Wiseley, Findlay.

The paper will deal with the replies to letters (in the form of questionnaires) sent to 200 doctors in the smaller communities of the State of Ohio, who are graduates of 10 to 15 years ago, asking them if they feel that their work could be improved by having facilities such as X-rays, electro-cardiograph, basal metabolism, and a laboratory under a competent man in their own community. A presentation of criticism of our present scheme of board of health work. The duty of the medical school to its graduates. Some phases of socialized medicine.

Discussion—2:30 to 2:35—Julien E. Benjamin, Cincinnati.

General Discussion—2:35 to 2:45.

Paper No. 2—2:45 to 3:00

THE STATUS OF SERUMS AND VACCINES FOR THE GENERAL PRACTITIONER—by W. G. Workman, National Institute of Health, Washington, D. C.

Discussion—3:00 to 3:05—Mr. Leo Ey, Columbus.

General Discussion—3:05 to 3:15.

Paper No. 3—3:15 to 3:30

PROFESSIONAL EDUCATION IN RELATION TO MODERN PUBLIC HEALTH—by Alfred Friedlander, Cincinnati.

Communities have done, or are doing, their part toward the solution of public health problems, such as purification of water supplies, inspection of food stuffs, disposal of sewage and garbage, control of communicable diseases. The individual physician must see that the public is properly advised as to facts, must see that proper practices are carried out. In industrial medicine and toxicology, the physician must be advisor to industry and public. The medical school must instruct its students as to advances in the field of public health, must train its students as to principles and practices for the carrying out of which the physician of the near future will be largely responsible.

Discussion—3:30 to 3:35—T. J. LeBlanc, Cincinnati (by invitation).

General Discussion—3:35 to 3:45.

Paper No. 4—3:45 to 4:00

NEW AND APPROVED METHODS OF COMBATING TUBERCULOSIS—by Theodore L. Bliss, Akron.

Patients having active pulmonary disease and a positive sputum spread tuberculosis. Collapse therapy helps to arrest the disease and to convert a positive sputum. In no way does it replace bed rest in treatment. Its indiscriminate use engenders disappointment and disrepute of the method, and it also subjects the patient to an unwarranted risk. The value of collapse therapy, when properly used, has been proved, and today, the problem is one of extending its application.

Facilities for case finding are necessary, particularly among contacts, since the undiscovered and untreated incipient case is a potential open case and source of infection.

Discussion—4:00 to 4:05—John H. Skavlem, Cincinnati.

General Discussion—4:05 to 4:15.

Paper No. 5—4:15 to 4:30

THE MEDICAL RELATIONS OF STATE AND FEDERAL RELIEF AGENCIES—

OPEN FORUM DISCUSSION—In charge of the Officers of the Section.

4:30—Business. Election of Officers.

Registration

General registration for all members and guests will be conducted at the registration headquarters which will be located on the Fourth Floor of the Netherland Plaza Hotel on which the commercial and scientific exhibits will be located and on which all sessions of the Annual Meeting will be held.

Admission to all Sections and General Sessions and to the special entertainments in connection with the meeting will be by badge only. Everyone in attendance must register to obtain a badge and therefore gain admission to the various sessions of the meeting.

Chapter 1, Sections 1, 2 and 3 of the By-Laws restricts registration and attendance at the Annual Meeting and its various sessions to members of the State Association in good standing. Physicians from outside Ohio who are members of their respective state medical associations, medical students and eminent members of scientific professions not medical but allied thereto, may be admitted as guests at the Annual Meeting.

Essayists-Discussants

"All papers read before this Association shall be its property. *Each paper shall be deposited with the Section Secretary when read.* Authors shall not cause papers read before this Association to be published as original elsewhere, nor until after they have been published in the official *Journal* of this Association."—Chapter IV, Section 3, By-Laws.

Discussants of papers are requested to forward typewritten copies of their remarks to the *Ohio State Medical Journal*, 1005 Hartman Theatre Building, Columbus, Ohio, not later than two weeks after the Annual Meeting in order that they may be published with the papers.

Eastern Standard Time

The time indicated in this program is Eastern Standard Time.

—OSMJ—

Licenses through reciprocity to practice medicine and surgery in Ohio have been issued to the following by the State Medical Board: Dr. J. Walter Johnson, Akron, Loyola University; Dr. Arthur G. King, Cincinnati, Harvard Medical College; Dr. Harrietta M. B. Marquart, Columbus, Loyola University; Dr. John D. Skow, Toledo, Rush Medical College; Dr. Morris M. Groban, Dayton, University of Michigan; Dr. George W. Hobson, Cleveland, University of Pittsburgh; Dr. George M. Wilcoxen, Alliance, University of Chicago, and Dr. John D. Cameron, Defiance, University of Michigan.

SPECIAL ATTRACTIONS, SUPPLEMENTING SCIENTIFIC PROGRAM, WILL ADD TO IMPORTANCE AND INTEREST OF THE 89TH ANNUAL MEETING, CINCINNATI, OCTOBER 2, 3 AND 4

MEMBERS of the State Association who have scanned the program for the 89th Annual Meeting published on the preceding pages, doubtless will agree that it is one of the best ever arranged for an annual session of the Ohio State Medical Association.

The Council Program Committee consisting of Dr. Parke G. Smith, Cincinnati, chairman; Dr. C. L. Cummer, Cleveland, and Dr. R. R. Hendershott, Tiffin, has worked diligently, in cooperation with the section officers, to provide presentations of general interest and importance. Some of Ohio's outstanding medical talent has been scheduled. Guest speakers of national reputation have been secured for the general sessions. The time schedule of the meeting has been re-arranged so that something of importance will be taking place almost every minute of the three-days session.

In addition to the excellent scientific sessions, special attractions have been arranged for those attending and the following brief comments on them are presented for the sake of emphasis:

Scientific Exhibit

A SPLENDID Scientific Exhibit has been arranged by Dr. Symmes Oliver, Cincinnati, chairman of the local Committee on Scientific Exhibit, and his committee consisting of Dr. Alfred Friedlander, Dr. Oscar Berghausen, Dr. Joseph Ganim, Dr. George Guest, Dr. Robert Kehoe, Dr. K. V. Kitsmiller and Dr. Cecil Striker.

Between 35 and 40 exhibits on a wide variety of subjects will be displayed in the spacious exhibit hall to the left of the Hall of Mirrors at the Netherland Plaza, the Annual Meeting hotel.

As Ohio physicians know, the Scientific Exhibit conducted annually by the American Medical Association in connection with its annual session has for many years been one of the feature attractions at that meeting.

An effort has been made this year by the Council Program Committee in cooperation with Dr. Oliver's committee to provide members of the State Association with an A.M.A. Scientific Exhibit in minature.

The request of the committee for exhibits met with a hearty response from physicians in all parts of the state. The result is a program of scientific exhibits and demonstrations of great value.

The scientific exhibits will be open during all sessions of the Annual Meeting and every physician in attendance should plan to take advantage of this fine opportunity to study firsthand the research work of and data assembled by his Ohio colleagues on many interesting and important medical problems.

It is planned to publish a complete schedule of the scientific exhibits in the October 1 issue of *The Journal* which will reach the members a few days before the opening of the Cincinnati meeting.

Annual Dinner

ALL attending the Cincinnati meeting should plan to attend the Annual Dinner on Thursday evening, October 3, sponsored by the Cincinnati Academy of Medicine.

For years the dinner session has been one of the outstanding events of the Annual Meeting. It is the feature social event in connection with the meeting and offers an opportunity for visiting physicians to get together with old colleagues and acquaintances for an evening of diversion.

This year's banquet will be held in the beautiful Hall of Mirrors at the Netherland Plaza with Dr. A. Graeme Mitchell, Cincinnati, as toastmaster. An address of welcome will be made by the Hon. Russell Wilson, mayor of Cincinnati.

This being the 100th anniversary of the first medical convention held in Ohio, the address of Dr. Jonathan Forman, Columbus, on "Highlights of the First Medical Meeting Held One Hundred Years Ago", will be timely and appropriate.

The Banquet Committee of the Cincinnati Academy, headed by Dr. Louis Feid, Jr., and com-

posed of Dr. Francis E. Cunningham, Dr. Hugh H. Hengstenberg, Dr. Daniel C. Rivers, and Dr. Emil R. Swepston, is arranging for a guest speaker of national importance for the feature address of the evening. The committee is not ready as yet to announce the name of the speaker but promises a pleasant surprise for those attending the dinner session.

Sale of tickets for the banquet will be handled by members of the Cincinnati Academy and will be available until a reasonable hour preceding the dinner. Physicians planning to attend should get their tickets early inasmuch as a large attendance is anticipated and an early check on the number expected will be necessary to facilitate banquet arrangements.

Hospital Clinics

IT will be noted that the schedule of hospital clinics arranged for visiting physicians by members of the Cincinnati profession has been included officially in this year's Annual Meeting program.

The hospital clinics will start at 8 a. m., Wednesday, October 2, and last until 1 p. m., when the first General Session and opening session of the House of Delegates will convene.

Heretofore there usually has been some conflict between the clinics and the first session of the Annual Meeting. This will be avoided this year and should result in many more physicians than customary having an opportunity to attend the medical and surgical clinics.

A program of the clinics can be obtained by telephoning the Cincinnati Academy Office, PArkway 2345, and plans will be made to have this information available at the various Cincinnati hotels.

Luncheon for Ex-Presidents

A luncheon to be given Thursday noon, October 3, at the Netherland Plaza, by the State Asosciation for all Past-Presidents of the Association will be one of the innovations in connection with the Cincinnati Annual Meeting.

The Committee on Arrangements and the Program Committee which jointly arranged for this luncheon are hopeful that all living ex-presidents will find it convenient to be the guests of the State Association at that time and participate in this reunion of former leaders of the Association, an event which is being planned as an annual affair during the Annual Meeting of the State Association.

Annual Golf Tournament

FIFTEENTH Annual Tournament of the Ohio State Medical Golfers' Association will be held on Tuesday, October 1, the day preceding the opening of the Annual Meeting, at the Maketewah Country Club, recognized as the championship course of the Cincinnati District.

The tournament plans are being completed by Dr. Ralph Hatfield, Dr. Wesley L. Furste, Dr. C. R. Deeds, Dr. C. A. Price and Dr. W. H. Ventress. Assisting them is Dr. Louis Feid, Jr., president of the Golfers' Association.

Every male member of the State Medical Association is eligible for affiliation with the Golfers' Association and to participate in the tournament upon the payment of $2.00 enrollment fee which covers life membership. Membership checks should be mailed to Dr. J. B. Morgan, Medical Arts Building, Cleveland, secretary-treasurer of the Golfers' Association, or pay the fee at the first tee on the day of the tournament.

A splendid array of prizes have been assembled by the Cincinnati committee which is anticipating one of the largest turn-outs in the history of the association.

Organization Luncheon

FRIDAY noon, October 4, the annual Organization Luncheon will be held in the Netherland Plaza's Pavilion Caprice. At that time the State Association will be host to the presidents, secretary-treasurers and legislative and medical defense chairmen, and correspondents to *The Journal* of the constituent county medical societies; officers, councilors and committeemen of the State Association; members of the House of Delegates; officers of the scientific sections; past-

presidents of the State Association; and delegates to the American Medical Association. Admission will be by printed invitation, sent by mail to those expected to attend.

The principal speaker at the Organization Luncheon will be Mr. A. D. Caddell, secretary, State Industrial Commission, who will discuss various questions in connection with the administration of the Workmen's Compensation Law of special interest to members of the medical profession.

New State Association officers, elected at the final session of the House of Delegates, Friday morning, will be introduced and, if time permits, various organization matters discussed.

For the information of members who have not as yet made hotel reservations for the Cincinnati meeting, a list of Cincinnati hotels, their rates and accommodations was published in the June and August, 1935, isues of *The Ohio State Medical Journal.*

It is suggested that those who have not written for reservations and received verification from the hotel selected, should do so immediately. Hotel accommodations are usually at a premium in Cincinnati because it is a convention, as well as a commercial, center. Moreover, a large attendance at the Annual Meeting is anticipated, so this should be taken care of promptly to insure the type of accommodations desired.

The luncheon will be started promptly at 12 o'clock so that it can be concluded in time for the scientific section meetings scheduled for 2 p. m.

—OSMJ—

Life Span of Ruralite Longer

According to tables recently compiled by the Statistical Bureau of the Metropolitan Life Insurance Company, the rural dweller, in the United States, has, on an average, four or five years longer life than the urban resident.

At birth a white male has an expectation of life of 56.73 years if an urban resident, and of 62.09 years if dwelling in a rural section. The corresponding figures for a white female are 61.05 and 65.09.

—OSMJ—

Effective July 1, the Workmen's Compensation Law for the state of New York, permitted injured workmen to select their own physicians, and provided that physicians applying for authorization to practice on compensation cases must be approved by their county medical society.

PROPOSED AMENDMENTS TO BY-LAWS WILL BE PRESENTED AT THE CINCINNATI MEETING

In compliance with Chapter 13, Section 1 of the By-Laws of the Ohio State Medical Association, i.e., "These By-Laws may be amended at any annual meeting of the House of Delegates by a majority vote of the delegates present at that session, if the proposed amendment has been published in *The Journal* at least one month before the annual meeting", Dr. J. H. J. Upham, Columbus, a delegate from the Columbus Academy of Medicine to the 1935 Annual Meeting of the State Association, October 2, 3 and 4, Cincinnati, has requested *The Journal* to publish in full the following proposed amendments to the By-Laws of the State Association, to be submitted by him at the first session of the House of Delegates at the Cincinnati meeting, Wednesday, October 2, at 1 p. m.

PROPOSED AMENDMENT NO. 1

That Chapter 8, Section 4, of the By-Laws relating to the collective duties of The Council, be supplemented as follows:

"The Council shall provide for and superintend the issuance of *The Ohio State Medical Journal.* It shall have authority to appoint a medical editor or publication board or committee, or both, and make any other provisions for publication of *The Journal* which in its judgment are feasible and practical. Such appointee or appointees shall serve at the pleasure of The Council, which shall have full discretionary power to promulgate rules and regulations governing the publication of *The Journal;* enumerate the powers and duties of the medical editor or publication board or committee, or both; and fix the terms and conditions of his or their appointment."

PROPOSED AMENDMENT NO. 2

That Chapter 9, Section 1 of the By-Laws be amended by deleting the line reading:

"2. A Committee on Publication," and renumbering the succeeding lines of the section.

PROPOSED AMENDMENT NO. 3

That Chapter 9, Section 3 of the By-Laws be deleted and the succeeding section numbers be renumbered "3", "4", "5" and "6", respectively.

—OSMJ—

Ironton—Dr. Will Payne, Willow-wood, has been appointed Lawrence County health commissioner, effective January 1, 1936.

PROCEEDINGS OF THE COUNCIL

Program and Other Annual Meeting Arrangements Approved; Medical Relief and Legislative Problems Considered at Meeting Held July 28

MINUTES

THE Council of the Ohio State Medical Association met in regular session in the headquarters office, Hartman Theatre Building, Coumbus, Sunday, July 28, 1935, at 1:00 p. m.

Those present were: President, Dr. Caldwell; President-elect, Dr. Hendershott; Ex-President, Dr. Cummer; Treasurer, Dr. Beer; Councilors, Drs. Smith, Huston, Klotz, Davidson, Kirkland, Brush and Seiler; Dr. Upham, chairman, and Drs. Alcorn and Platter, members, Policy Committee; Executive Secretary Nelson and Assistant Executive Secretary Saville.

The minutes of the meeting of the Council held on Sunday, June 2, 1935 (pages 528 to 532, inclusive, of the July, 1935, issue of *The Journal*) were read, and there being no corrections or additions, on *motion* by Dr. Huston, seconded by Dr. Seiler and *carried*, were *approved*.

1935 ANNUAL MEETING, CINCINNATI

Dr. Smith, chairman of the Council Program Committee and chairman of the Council Committee on Arrangements for the 89th Annual Meeting, Wednesday, Thursday and Friday, October 2, 3 and 4, at the Netherland Plaza, Cincinnati, reported on a meeting of the Program Committee held immediately preceding the meeting of the Council.

The Program Committee requested permission to invite certain physicians and interns exclusively engaged in medical research who are not active members of the State Association to appear as co-authors or discussants on the 1935 Annual Meeting program. On *motion* by Dr. Huston, seconded by Dr. Klotz and *carried*, such authorization was granted and the committee instructed to designate in the program that these essayists or discussants will appear on the program "by invitation".

The question of securing stenographic reports of discussions at the scientific sessions was considered. An estimate of the expenses of such an undertaking was presented by Dr. Smith. On *motion* by Dr. Brush, seconded by Dr. Klotz and *carried*, it was decided *not* to employ stenographic reporters but that the officers of the scientific sections should be instructed to announce that discussants should submit to the Publication Committee summaries of their remarks so that they can be published in connection with essays, if approved by the committee.

On *motion* by Dr. Huston, seconded by Dr. Davidson and *carried*, the program as prepared and presented to the Council by the Program Committee was approved with instructions that it be published in the September issue of *The Journal*. (See pages 679 to 690).

Dr. Smith reported on arrangements for the Scientific Exhibit. He stated that approximately 35 scientific exhibits had been arranged to date, and that he anticipated approximately 40 exhibits would be presented. The question of providing scientific exhibitors with viewboxes and special wiring facilities was discussed. On *motion* by Dr. Huston, seconded by Dr. Hendershott and *carried*, the Council authorized the expenditure of an amount not to exceed $800 to defray expenses in connection with the Scientific Exhibit.

Dr. Smith reported that the committees on arrangements of the Cincinnati Academy of Medicine had completed preliminary details for the meeting and are hard at work on necessary arrangements to make the Cincinnati meeting one of the best in the history of the State Association. He announced that through the central telephone exchange of the Cincinnati Academy, arrangements have been made for a special wire into the Netherland Plaza for the convenience of visiting physicians during the Annual Meeting. He pointed out that physicians could leave word at their offices that they can be located promptly by calling PArkway 2345, Cincinnati, the central telephone exchange, which in turn will communicate with them at the hotel.

The executive secretary was authorized by the Council to complete arrangements for sending to each member of the State Association a communication notifying him of the Annual Meeting, the expenses of preparing and mailing the "official call" to be defrayed from Annual Meeting revenue.

POOR RELIEF PROBLEMS

Dr. Upham, chairman of the Policy Committee, reported on new developments in connection with medical care of those on relief, discussed at a meeting of the committee held on the morning of this day. He called attention to an article on the new rules and regulations governing the FERA medical plan in Ohio, published in the July 1 issue of *The Journal*, pages 534-536. Various members of the Council reported that many members in their respective districts considered the

new regulations a distinct improvement over the old ones, and that the medical program appears to be operating more efficiently in most counties.

Communications from several counties pointing out there has been extended delay in the payment of physicians' bills for the care of those on relief were read. Dr. Upham pointed out that these matters had been taken up with FERA officials in Columbus, who have promised to speed up payments and clarify some of the new rules and regulations for local relief directors. Mention was made that relief officials had pointed out that some of the delays have been due to carelessness on the part of some physicians in filling out reports, fee bills, etc.; also failure on the part of some local relief directors to promptly transmit to the Columbus FERA office such documents.

Dr. Upham said that the Policy Committee was deeply concerned over difficulties likely to arise when and if the FERA drastically curtails financial aid for relief or completely withdraws from the field of direct relief, and turns over to local political subdivisions the responsibility of providing relief, including medical care, for all persons unable to find employment in private industry or on Federal relief projects. He called attention to the fact that this situation would be covered in detail in an article in the August 1 issue of *The Journal*, pages 611 to 613, and expressed the hope that all Councilors would emphasize to the officers of the societies in their districts the necessity for immediate conferences with local governmental officials so that a local program adequate to meet local conditions could be worked out in advance and ready for operation when and if the federal government curtails funds for direct relief. It was pointed out that the Governor is contemplating calling a state-wide conference on relief problems and that efforts would be made to have representatives of the State Medical Association present at such conference and the views of medical organization presented.

The Carey Poor Relief Act enacted at the regular session of the General Assembly this year was discussed. The Policy Committee was instructed to secure, if possible, a clarification of some of its provisions, especially those relating to which local governmental agency will be held responsible for providing medical care for unemployables so that accurate information can be transmitted to the various medical societies and they will know which group of officials are the proper ones to contact on medical relief matters.

The Policy Committee reported it is considering drafting a communication to be sent to all the county medical societies, in which would be incorporated suggestions on local medical relief programs and reference made to principles and policies that should be adhered to in formulating such programs. This met with general approval on the part of the Council, and the committee was unofficially instructed to follow out this idea.

MEDICAL CARE OF INJURED WPA EMPLOYES

The Council was informed that compensation and medical care for those injured while employed on projects under the new Works Progress Administration will be provided by the U. S. Employes' Compensation Commission. Rules and regulations just issued by that commission were discussed. (Detailed summary of regulations will be found on pages 701-703 of this issue of *The Journal*). The Council expressed satisfaction over the fact that the regulations do not provide for a standardized schedule of medical and surgical fees. It was felt that fees paid to physicians for the care of injured WPA employes should not be less than the fees contained in the current general medical and surgical fee schedule of the State Industrial Commission. The Policy Committee was instructed to discuss the matter with State WPA officials and, if possible, get them to instruct district supervisors to request physicians attending WPA cases to charge fees comparable to those in the Workmen's Compensation Fee Schedule.

POLICY ON MINIMUM FEE SCHEDULES

Dr. Upham informed the Council that the Policy Committee had carefully studied correspondence received by the State Headquarters Office from several county medical societies, relative to the advisability of establishing minimum local fee scedules for medical care of indigents. He said the committee, after reviewing the previous policy of the State Medical Association on this question (April, 1928, issue of *The Journal*, page 302; and May, 1932, issue, page 353), and discussing thoroughly the legal angles, recommended that the Council adopt the following statement of policy to guide the component county medical societies on this and other questions in connection with medical relief activities:

STATEMENT OF POLICY

In correspondence and otherwise, the advice of the Committee on Public Policy has been sought relative to the advisability and legality of action on the part of county medical societies in establishing minimum standard fee schedules for medical services to indigents.

Also, the committee has been requested to consider the possibility of sponsoring legislation to amend the present Poor Relief Laws and make mandatory the payment of medical fees by county, township and municipal officials which are commensurate with the services rendered by physicians.

After much study of these questions and reviewing existing policies of the State Association bearing on them, the committee herewith presents to the Council for consideration and action the following recommendations to guide the component county medical societies in their negotiations with local poor relief officials:

1. It is desirable and important that frequent

conferences be held by the representatives of medical organization and county, township and municipal poor relief officials, in an effort to establish local medical relief programs mutually agreeable to physicians, relief officials and indigent patients.

Upon authorization of the county medical society, the representatives of the society should be prepared to suggest to relief officials minimum fees for various types of medical services rendered the indigent and should endeavor amicably to reach an agreement with relief officials that in so far as practicable and feasible, the suggested fees will be paid by such officials to compensate physicians for their care of the poor.

However, it is recommended that county medical societies avoid any official action that could be interpreted or construed to mean the adoption of an official standard fee schedule or as an attempt to coerce individual physicians into adhering to such suggested fees in the presentation of bills to relief officials.

It is believed that such action on the part of a county medical society might lead to legal difficulties or embarrassment. Doubtless it would be misunderstood by that portion of the public able and willing to pay the prevailing customary fees for medical care.

In the final analysis, we fear that any attempt on the part of a county medical society to standardize medical fees through compulsion or threat of disciplinary action might be construed as a violation of Section 6391 of the General Code of Ohio and believe that such action would be in conflict with the inherent right of every physician to exercise his own judgment in professional matters so long as his actions are in conformity with existing legal requirements and in accord with sound public policy and medical ethics.

The wise and safe policy for each county medical society to pursue is to establish through frequent conferences and cooperative efforts, friendly relations with poor relief officials and subsequently convince such officials of the justness of fairly compensating physicians for their services to recipients of poor relief.

2. Ohio's present poor relief statutes are inadequate and antiquated. They should be modified, supplemented and recodified. The provisions pertaining to medical care of the poor are ambiguous and incomplete. Medical organization, we believe, should lend its support to constructive efforts to revise and recodify these statutes.

However, we are opposed to insertion in the poor relief statutes of a definite state-wide medical fee schedule governing physicians' services to the indigent, or reference to fee schedules established by administrative order.

Standardization of medical fees through legal enactment for services to the indigent would in all probability lead the public to believe that such fees constitute the "legal fees" for private practice. Litigation and embarrassment would result. Obviously, it would be difficult to maintain fees for private practice on a level comparable to the ability of the private patient to pay for the services received from his private physician.

It is impractical and not feasible to apply a standard fee schedule for the entire state. Fees should be adjusted locally with the customary fees charged in the respective locality as the basis for negotiations. This is consistent with the previous policy of the State Medical Association and should be adhered to.

On *motion* by Dr. Brush, seconded by Dr. Davidson and *carried*, the foregoing statement was *approved*.

MEDICAL CARE OF INDIGENT TRAFFIC VICTIMS

The attention of the Council was called to correspondence suggesting the possibility of amending the statutes providing for the compensation of hospitals for the care of indigents injured in motor vehicle accidents to include provision for the payment of physicians attending such persons, the fees to be paid by the Bureau of Motor Vehicles out of the funds raised from the sale of automobile license tags. The Policy Committee reported that it had again studied this question and pointed out to the Council the existing policy of the State Association against legislation of this character (January, 1933, *Journal*, page 46, and January, 1935, *Journal*, page 38).

On *motion* by Dr. Brush, seconded by Dr. Huston and *carried*, the Council instructed the Policy Committee to continue its consideration of this matter. In this connection it was pointed out that in all probability proposed legislation of this character could not be introduced or considered by the Legislature until its next regular session in 1937.

MEDICAL CARE OF OLD AGE PENSIONERS

Dr. Upham reported that additional conferences had been held with officials of the Division of Aid for the Aged on problems in connection with providing recipients of old age pensions with proper medical care. He said that the action of the Council at its last meeting in expressing the opinion that this was a local problem and should be worked out by local old age pension officials and representatives of the local medical society, had been explained to state old age pension officials and that they had instructed their local administrators to contact the secretary of each county medical society immediately to secure the advice and cooperation of the society on this matter. Attention was called to the bulletin issued under date of July 19 by the State Headquarters Office to county society secretaries, summarizing the new developments on this question.

SERIOUS LEGISLATIVE PROBLEMS

The Policy Committee called attention to the fact that a special session of the Ohio General Assembly undoubtedly will be held sometime this Fall, primarily to consider taxation proposals. Attention was called to the article in the August 1 issue of *The Journal* and a recent legislative bulletin, in which the taxation question was summarized in detail and the danger of the enactment of an amendment to the sales tax to extend such tax to professional and non-professional services was emphasized. The possibility of the enactment of an income tax, gross receipts tax, and even an occupational tax also was discussed.

It was pointed out that the Legislature may be asked to consider far-reaching amendments to the Workmen's Compensation Law and to enact a social security program patterned after the Federal Social Security Act recently enacted by the U. S. Congress. Dr. Upham, on behalf of the Policy Committee, requested members of the Council to stimulate interest among the members in their respective districts in legislative activities. He emphasized that medical organization must be prepared to take an active interest in the anticipated special sessions of the General Assembly inasmuch as many proposals of direct interest to physicians undoubtedly will be considered.

On *motion* by Dr. Davidson, seconded by Dr. Huston and *carried*, a vote of commendation and appreciation was extended by the Council to the members of the Committee on Public Policy and the headquarters office personnel for the effective way they have handled recent poor relief and legislative problems.

REPORT ON RECENT A. M. A. MEETING

Reports on the recent Annual Session of the American Medical Association in Atlantic City were made by Drs. Brush, Cummer and Upham, supplementing the articles published in the July issue of *The Journal*, page 537, and in the June 22 and June 29 issues of the *Journal of the American Medical Association*. It was pointed out that the Ohio delegation, as usual, took a prominent part in the meeting and that an unusually large number of Ohio physicians participated in the scientific program. The action of the A. M. A. House of Delegates in again definitely expressing opposition to the socialization of medicine, compulsory sickness insurance, etc., was summarized. Special attention was called to the splendid report by the Bureau of Medical Economics of the A. M. A., in which the good and bad features of approximately 200 medical service plans now in operation were reviewed.

The Council was informed that the headquarters office is endeavoring to secure a sufficient number of copies of this report so that a copy can be sent to each member of the State Association.

Correspondence from Dr. Olin West, secretary and general manager of the A. M. A., calling attention to the fact that the 1936 session of the A. M. A. probably would be held about the middle of May, was read.

SPEAKERS' BUREAU

A report by the Special Committee on Extension of Activities stated that the committee has been in correspondence with the secretaries of a dozen or more state medical associations and has secured valuable information relative to speakers' bureaus or similar activities by medical societies in other states. The committee stated it is contemplating submitting to the Council at some future date suggestions for a similar undertaking on the part of the State Association, but that it desired more time for consideration of the question. Attention of the individual Councilors was called to the arrangements approved by the Council whereby a sum not to exceed $200 per district will be paid by the State Association to help defray the expenses of district society meetings and programs, and the Councilors requested to instruct their district societies as to how to take advantage of this arrangement if they care to do so.

Dr. Klotz reported that the annual meeting of the Northwestern Ohio Medical Association will be held at Marion on September 24. He extended an invitation on behalf of that association to the members of the Council and officers of the State Association to be present if convenient for them to do so.

COMMUNICATION FROM COMMITTEE ON PREVENTIVE MEDICINE

A report on a meeting of the Committee on Preventive Medicine and Periodic Health Examinations held in Columbus, June 23, 1935, was submitted for the information of the Council.

On *motion* by Dr. Cummer, seconded by Dr. Smith and *carried*, the Council *approved* the following recommendations of the committee:

1. That the committee be authorized to cooperate with and assist the State Department of Health in the formulation of a series of two or three brief articles on prenatal care to be distributed to the newspapers of the state.
2. That the Council, when and if requested by the State Department of Health to do so, appoint a representative on the contemplated advisory council to be established by the State Department of Health to assist in administration of a maternity and infancy program financed with funds provided under the Federal Social Security Act.
3. That the committee be authorized to have prepared a series of articles on preventive medicine for publication in the *Ohio State Medical Journal* following approval by the Publication Committee.

The Council discussed a resume of proposed activities contemplated by the Ohio Academy of Pediatrics to stimulate among general practitioners preventive services such as immunization, periodic health examinations for children, etc., presented in the report of the Committee on Preventive Medicine and Periodic Health Examinations.

On *motion* by Dr. Cummer, seconded by Dr. Smith and *carried*, the Council recommended that in communications from the State Headquarters Office the county medical societies be requested to schedule from time to time on their programs, speakers on the subject of pediatrics, especially that phase dealing with preventive services for children.

It was the sense of the Council when and if a speakers' bureau is established by the State Asso-

ciation, such bureau could consider adding to the list of speakers recommended by the bureau, essayists nominated by the Ohio Academy of Pediatrics.

WORKMEN'S COMPENSATION DEVELOPMENTS

A communication from the Hon. Thomas M. Gregory, chairman of the State Industrial Commission, acknowledging receipt of an official communication from the Council respectfully requesting the State Industrial Commission to eliminate the 20 per cent reduction in medical and surgical fees paid to physicians for the care of workmen's compensation claimants, was read. Mr. Gregory stated in his letter the Commission has the matter under consideration and hoped to reach an early decision. On *motion* by Dr. Davidson, seconded by Dr. Cummer and *carried*, the Special Committee on Workmen's Compensation was instructed to continue its negotiations with the Industrial Commission and, if necessary, submit additional data to the Commission in an effort to get the Commission to rescind its order placing a 20 per cent reduction on physicians' fees. The Council was informed that the Commission at present is severely handicapped in administrative procedure due to drastic curtailments in its budget made by the Governor.

ANNUAL REPORTS

Dr. Caldwell, the President, reported that chairmen and members of the standing and special committees are cooperating in an excellent way with the State Headquarters Office in the preparation of annual committee reports and that such reports would be published, as usual, in the October 1 issue of *The Journal* immediately preceding the Cincinnati meeting.

The Council discussed in detail the suggestion of the President that each Councilor formulate an annual report on his district in which would be summarized activities of the various county medical societies throughout the year and the Councilor's personal observations of the work of the different societies. The majority of the members of the Council expressed approval of the idea. However, it was felt that it would be impractical to attempt this at this late date and that some definite plan for putting the idea into effect should be worked out so that arrangements could be made for such Councilor reports at the 1936 Annual Meeting. The question was referred to the Committee on the Extension of Activities for consideration and recommendations.

MISCELLANEOUS

The Council was informed that Dr. Jonathan Forman, Columbus, with the approval of the Publication Committee, is having prepared a series of articles on historical events in Ohio Medicine for publication in *The Journal*.

A report was made on conferences held with officials of the State Tax Commission relative to exempting medical societies from payment of the admissions tax on revenue from tickets sold to those attending special postgraduate lectures held under the auspices of the society. It was pointed out that medical societies, being educational in character, should be entitled to exemption under the Ohio Admissions Tax Law, as they are under the Federal Admissions Tax Law, and that arguments in support of this contention had been presented to the Tax Commission which has the question under consideration.

Correspondence with the American Foundation Studies in Government, Philadelphia, Pa., was read, and the President was authorized to submit to the organization a list of names of Ohio physicians who might be interested in receiving literature and reports on public health questions prepared by the Research Division of the Foundation.

A communication from the Columbus Chamber of Commerce stating that it contemplated inviting the Association of American Medical Colleges to hold its 1936 meeting in Columbus, was discussed.

A report on membership statistics showed that there were 5,250 members to date for 1935, compared with 5,158 on the same date in 1934, and with a total for 1934 of 5,361.

There being no further business, the Council adjourned to meet on Tuesday, October 1, the day preceding the Annual Meeting in Cincinnati, October 2, 3 and 4.

Signed:,

JAMES A. BEER, M.D.,
Acting Secretary of Council.

—OSMJ—

Lima Academy Will Hold Annual Post-Graduate Course, Sept. 23-27

A post-graduate course will be given September 23 to 27 by the Academy of Medicine of Lima and Allen County.

On September 23, Dr. Robert F. Ridpath, Temple University, will discuss "General Symptoms and Ear Conditions", from 5 to 6 P. M., and "Laryngeal Conditions and Treatment", from 6 to 7 P. M. From 5 to 7 P. M. on September 24, he will lecture on "Diagnosis of Accessory Nasal Sinuses".

Dr. Edward B. Davis, associate of Dr. Joseph B. DeLee, Chicago, will discuss "Physiology and Conduct of Normal Labor", 5 to 6 P. M., and "Forceps Operation", 6 to 7 P. M., September 25.

His subjects at the same hours on September 26, will be "Treatment of Face and Breech Presentation", and "Episiotomy and Repair"; and on September 27, "Complications of Second Stage", and "Prevention and Treatment of Eclampsia".

Details concerning this post-graduate course can be secured from Dr. Edward B. Pedlow, Lima.

DIRECT RELIEF FUNDS, INCLUDING SUMS FOR MEDICAL CARE, CUT AS FERA PREPARES TO TAPER OFF FINANCIAL AID AND WORKS PROGRESS PROGRAM GETS UNDER WAY

DEVELOPMENTS during August in the Ohio relief program brought additional serious problems in providing medical care for indigents and temporarily unemployed and revealed some of the difficulties which may be anticipated during ensuing months.

In line with the announced intention of the Federal Government to withdraw from the field of direct relief and return this responsibility to the state and local political subdivisions, the Federal Emergency Relief Administration applied drastic cuts to the amounts allocated to all states for direct relief during August.

Confronted with this situation, the FERA in Ohio was compelled to curtail amounts allocated to all Ohio counties and apply a slash of between 35 per cent and 50 per cent in local direct relief budgets in comparison to July budgets.

This meant that all county relief directors had to adjust their expenditures for food, clothing, shelter, medical care, etc., during August to meet this reduction in available funds.

NECESSITY FOR FUNDS STRESSED

Officials of the State Medical Association emphasized to FERA officials the necessity of providing adequate funds for local medical relief programs and pointed out that in many counties the funds available for medical care of those on relief have never been sufficient to make the prorating of bills for professional services unnecessary.

FERA officials admitted that even under the revised medical regulations barely enough funds would be available in many counties for paying physicians' bills in full and expressed a desire to cooperate in every possible way with local relief directors and the medical profession in trying to solve this problem.

However, they pointed out that action of the FERA at Washington in slashing Ohio's allocation for August had forced them to take drastic action and insisted that expenditures for all direct relief activities, including medical care, would have to be reduced uniformly.

The hope was expressed at the FERA office that the situation would be alleviated by the transfer of many employables from the direct relief rolls to Works Progress Administration projects and that many local subdivisions would have some funds available for relief activities.

REVISED REGULATIONS STILL IN EFFECT

It was agreed that the medical program provided for in the Medical Manual as revised July 1, 1935, should be continued.

However, county relief directors were instructed to apply the same percentage used in reducing direct relief budgets to the total amount of money available under the revised medical regulations for medical services.

That is if the direct relief budget of a county was cut 40 per cent for August, it was necessary for the local relief director to keep his expenditures for medical services in that month at 60 per cent of an amount arrived at by multiplying $1.00 by the number of families and $.25 by the number of single persons on relief for the month of July.

No change was ordered in the regulation separating bills for drugs and medical supplies from bills submitted by physicians, dentists and nurses, but of course drug bills were subject to the percentage cut made in the total direct relief budget.

It was pointed out that doubtless this procedure would be followed in succeeding months when it is anticipated further reductions in direct relief allocations would be made by the FERA.

What happened in August will be amplified in September if the Federal Government follows out its present plan.

U. S. TO QUIT DIRECT RELIEF

Recent press dispatches from Washington have quoted Harry L. Hopkins, FERA administrator and head of the new Works Progress Administration, as predicting the Federal Government will start shutting off direct relief to whole states by September 1 and be out of the field of direct relief entirely by November 1.

Mr. Hopkins states that the Federal Government is serious in its intention to put 3,500,000 persons now on the direct relief rolls to work on WPA projects by November 1 and transfer to states and local communities the responsibility of caring for persons unable to secure WPA jobs or employment in private industry.

If this procedure is carried out, further reductions in direct relief funds by the FERA may be expected for September and October, with complete curtailment by November 1.

NO STATE PROGRAM FORMULATED

Little progress has been made by the State Administration in formulating a state-wide relief program to carry on where and when the Federal Government leaves off.

The Governor has been quoted as intimating he favors leaving this responsibility to counties and municipalities under the authority delegated

to them in the recently enacted Carey Act which also permits counties to issue relief bonds to finance local relief activities.

As emphasized in the August issue of *The Journal*, county medical societies must be prepared to meet this situation. It has been suggested in bulletins issued by the Committee on Public Policy of the State Association that contacts be made immediately with local officials likely to be placed in charge of local relief activities and efforts be made to agree upon a medical relief program mutually satisfactory to relief officials and the medical profession. Each medical society should be represented by an alert and aggressive medical advisory committee which can be retained to confer with local relief officials when and if the FERA folds up.

As a result of conferences held by members of the Committee on Public Policy of the State Association with Ohio FERA officials, a bulletin clarifying the provisions and meaning of Paragraph f of Section 1 of the Revised FERA Medical Rules and Regulations has been issued to all county relief directors.

The provision reads as follows:

"Where the subdivisions have regularly employed physicians on a salary or fee basis, Federal funds may not be used to replace this service. Any physician receiving a stipulated salary from a subdivision for medical care for indigents may not receive payment from FERA funds for treatment of relief clients."

The modified interpretation of this paragraph issued by the FERA sets forth that where a physician is employed by a political subdivision to render medical service to the indigent, he may not participate in the FERA medical relief program. However, a physician employed on a part-time basis as health commissioner or engaged in other activities solely in the field of preventive medicine, may participate in the FERA medical relief program. Health commissioners employed on a full-time basis are not eligible for participation in the medical relief program.

FERA officials insisted that physicians employed on a full-time basis as health commissioners or for public health work would be expected to devote their entire time to public health activities and should not be considered as actively engaged in the practice of medicine.

This new ruling will permit a number of physicians employed on a part-time basis in the field of preventive medicine who had heretofore been excluded from the FERA program to receive fees for services rendered relief patients.

WORKS PROGRESS PROJECTS STARTED; 30,000 GET EMPLOYMENT IN OHIO

It is too early to determine what effect the Works Progress program will have on the relief situation in Ohio.

A total of 1350 Ohio WPA projects, giving employment to 30,000 persons, have been started. It is the hope of WPA officials to double the number of projects and the number of persons employed during the next month.

Persons employed on WPA projects will be paid monthly wages, ranging from $40 to $94. When employed, they will be taken from the relief rolls and be expected to provide themselves and their families with all necessities, including medical care.

The wages paid are determined by the location of the project and the type of work done. Subsistence requirements of the person employed and his family are not taken into consideration.

It is estimated there are approximately 275,000 employables on the direct relief rolls in Ohio and approximately 50,000 unemployables. It is hoped to provide WPA jobs for all of the first group by November 1. The 50,000 unemployables will be taken care of temporarily by the FERA and eventually turned over to the relief agencies of local subdivisions.

DISTRICT ADMINISTRATORS LISTED

The WPA program in Ohio is directed by Charles C. Stillman, who will retain his position as head of the FERA in Ohio.

The state has been divided into 16 WPA districts, each in charge of an administrator, as follows:

No. of District	Counties	Administrator	Headqrts.
1.	Ashtabula, Lake, Geauga, Portage, Trumbull.	Robert Owens	Warren
2.	Mahoning.	Ralph Vail	Youngstown
3.	Stark, Columbiana, Carroll, Tuscarawas, Harrison, Jefferson.	Frank Ritter	Canton
4.	Licking, Fairfield, Perry, Muskingum, Coshocton, Morgan, Guernsey, Belmont, Monroe, Noble.	L. C. Gibson	Zanesville
5.	Hocking, Athens, Washington, Vinton, Meigs, Gallia, Jackson, Lawrence.	Ray Noble	Athens
6.	Cuyahoga.	Waldo Walker	Cleveland
7.	Summit.	Merle Paul	Akron
8.	Ottawa, Sandusky, Seneca, Erie, Huron, Lorain, Medina.	M. B. Wittman	Sandusky
9.	Wyandotte, Crawford, Marion, Morrow, Ashland, Wayne, Knox, Holmes, Delaware, Richland.	Earl A. Nist	Mansfield
10.	Franklin.	C. C. Darby	Columbus

11. Clinton, Fayette, Pickaway, Ross, Highland, Brown, Adams, Pike, Scioto.	L. L. Henninger	Chillicothe
12. Lucas.	Wm. B. Schmuhl	Toledo
13. Williams, Fulton, Defiance, Henry, Wood, Paulding, Putnam, Hancock, Van Wert, Allen, Hardin, Auglaize, Mercer.	Fred Roose	Lima
14. Darke, Shelby, Logan, Union, Miami, Champaign, Clark, Greene, Madison.	Ralph Geiser	Springfield
15. Preble, Montgomery, Butler, Warren.	Harry Derivan	Dayton
16. Hamilton, Clermont.	L. A. Gillett	Cincinnati

RULES AND REGULATIONS GOVERNING MEDICAL CARE OF INJURED WPA MEN

Those injured on WPA projects will be paid compensation for lost time and permanent disability and provided with medical and hospital care.

This phase of the WPA program will be administered by the United States Employes' Compensation Commission at Washington, with suboffices in connection with state WPA offices.

Of particular interest to physicians are the special rules and regulations governing compensation and medical attention for disabled WPA employes, issued July 15, 1935, by the United States Employes' Compensation Commission.

A resume of these rules and regulations follows, and it is suggested the proper committee from each county medical society immediately contact its district WPA administrator for the purpose of discussing the regulations and working out agreements with him as provided for in the regulations:

Traumatic injury is defined as "injury by accident causing damage or harm to the physical structure of the body and shall not include a disease in any form except as it shall naturally result from the injury".

While the procedure under these new regulations is somewhat similar to that followed during the old Civil Works Administration, it is reasonable to expect that as a result of the experience gained in auditing bills submitted under the CWA, settlement of physicians' bills will be expedited.

The United States Employees' Compensation Commission is authorized to make necessary rules and regulations for this purpose and to decide all WPA injury questions.

The state works progress administrator will appoint a state compensation officer, who will be charged with the duty of supervising the handling of compensation claims.

Only graduates of recognized medical schools, with a degree of M.D., who are licensed to practice medicine in the state in which they reside, will be compensated by the Commission for medical treatment of injured WPA employees.

DESIGNATION OF MEDICAL ATTENDANTS

Employees of the WPA who suffer a traumatic injury in the performance of duty are entitled to medical and hospital care necessitated by such injury. Under no circumstances shall treatment be authorized for illness or disease in any form except as it shall naturally result from a traumatic injury by accident, causing harm or damage to the physical structure of the body. No provision is made for medical examinations to determine an employee's physical qualifications for work, and the Commission cannot pay for such examinations.

Medical treatment is to be furnished by existing federal medical establishments where practicable, and while such facilities must be used to the extent they are available, they must not be utilized to the exclusion or disadvantage of any other beneficiary for whom they have been specifically provided.

Where federal medical facilities are not available, or are inadequate to furnish necessary services, the state compensation officer or his local representative is instructed to make arrangements for medical care by reputable private physicians.

FEES AND LOCAL COOPERATION

Medical fees will be paid at rates not in excess of the minimum charge prevailing in the community for similar services.

The state compensation officer or his local representative is instructed to contact the local medical societies to enlist their cooperation in selecting physicians in the locality who are especially well qualified by training and experience to render service in industrial accident cases and who desire to participate in this service under the regulations of the Commission. The regulations state that under no circumstances should there be discrimination against any physician, otherwise qualified, because he is not a member of a medical society. Compensation cases are to be distributed among physicians in as equitable a manner as possible. A cumulative list must be kept by each local representative of the state compensation officer to show the number of cases referred to each physician.

The local compensation representative is instructed to secure advice as to the suitability (e.g. proximity, quality of service and general qualifications for specialized services) of local hospitals from medical advisory councils, hospital associations, hospital, health or similar councils, county medical societies and boards of health.

SELECTION OF HOSPITAL

A physician authorized to treat an injured employee may select the hospital, provided the latter

agrees to the schedule of rates which has been agreed upon by the Commission and representatives of the national hospital associations for services to Works Progress Administration employees. Hospital records of these patients shall be open to authorized representatives of the Commission, and the Commission reserves the right to examine patients and to cause the patient's removal for sufficient reason.

The local compensation representative will be required to follow up all cases under private medical care, secure medical reports, and to endorse each voucher for medical services, before it is forwarded to the state compensation officer, certifying that the services covered therein have been rendered to the injured person.

PROCEDURE RELATIVE TO FORMS

Special Form CA-16 or a letter containing the information required by that form must be issued by the person in charge of a project, or the compensation representative, in sending an injured employee to a physician or hospital for treatment, in cases in which there is no doubt concerning the right of the employee to receive medical care. This request is made in duplicate, the original being left with the physician or hospital. It is the physician's authority for rendering services for the account of the Commission and bills can not be paid in the absence of such authority.

If there is doubt whether the disability of an employee is due to an injury sustained in the performance of duty, the person in charge of a project or the local compensation representative should send the employee for examination with Special form CA-17. If the medical examination discloses that the condition for which treatment has been requested is not due to a traumatic injury while in the performance of duty, the local compensation officer or other person who issued Form CA-17 would immediately notify the physician or hospital that no treatment should be rendered for the account of the Commission. If the local compensation officer is in doubt concerning the matter following the medical examination and consultation with the examining physician, all details and circumstances should be immediately referred to the state compensation officer for advice. Form CA-17 authorizes emergency treatment pending receipt of such advice. If the state compensation officer is in doubt, he is to refer the facts to the Commission in Washington for decision.

Specific regulations cover hernia cases. In these cases Form CA-17 must be used in conjunction with Form CA-32. No hernia operations can be authorized by the state compensation officer, but should be reported to the Commission for handling, except, that in an emergency due to strangulation or incarceration, where it is clear that the complication is due to injury on a WPA project, an emergency operation may be authorized locally.

RULE ON CHANGING PHYSICIANS

Authorization for treatment of injured WPA employees should not be issued to more than one physician. If a second physician is necessary, the attending physician has full authority to procure such assistance as he may deem necessary. If it is essential for the welfare of the injured employee, or for other essential reasons, to change physicians, authority for treatment should be issued to the physician to whom the case is transferred. The first physician should be called on to submit all his charges to date on Form S-69 and the reasons for the change of physicians reported to the state compensation officer for transmission to the Commission.

Authorization for treatment, Form CA-16, should be issued on the date of injury or date employee applies for treatment and sent to the physician at the time the employee is referred for treatment. Emergency cases may be referred for treatment before issuance of Form CA-16, provided this form is issued within 48 hours thereafter. Where it is impracticable to observe this requirement, the delay in issuing written au-

All district WPA supervisors have been instructed by the Columbus headquarters of the WPA to get in touch immediately with the county medical societies of their districts and work out with them the details of preparing the panel of eligible physicians to handle WPA injury cases.

This is important and a responsibility the officers or proper committee of each county society should promptly assume.

Each injured employe will be given an opportunity to select his own physician from the panel of eligible physicians located in the vicinity of WPA project on which he was working at the time of injury.

Also instructions have been issued to keep the paper work required by physicians at a minimum and for the WPA offices to make out duplicate reports from the originals filled out by physicians.

No uniform schedule of fees has been established, and none probably will be. Physicians will be expected, under the regulations, to charge fees comparable to the minimum fee prevailing in the community for similar services.

All medical bills will be checked and paid direct by the U. S. Employes' Compensation Commission at Washington.

thorization must be satisfactorily explained, otherwise payment for medical services may be refused by the Commission.

All authority for treatment or hospitalization should be signed personally by the issuing officer. The name of the issuing officer typed on the form is not considered valid authority.

NURSING SERVICE AUTHORIZED

Attending physicians are authorized to engage special nursing service where such special care is absolutely essential. Written authorization from the compensation officer is not required for the services of nurses engaged by the attending physician. The Commission's allowance for hospitalization covers all general nursing service, and therefore the necessity for special nursing must be shown in each case. Vouchers submitted by nurses should certify that they are not employed on a salary basis by the hospital, in which the service was rendered, and their vouchers must be approved by the attending physician.

X-ray plates should not be forwarded to the Commission unless specific request is made therefor.

PREPARATION OF VOUCHERS

Vouchers (Form S-69) for medical, surgical, or hospital services and medical supplies, accompanied by a copy of the request (Special Form CA-16 or Special Form CA-17) should not be paid locally, but should be transmitted to the Commission for direct settlement. A separate voucher must be submitted by each payee for services to each injured employee.

Vouchers from physicians and hospitals on Form S-69, verified by the signature of the injured employee, should be submitted when the employee is discharged from treatment, except when hospitalization or treatment extends more than 30 days, in which event voucher Form S-69 should be submitted at the end of each 30-day period with a complete report from the attending physician showing the condition of the employee, the diagnosis and prognosis, and recommendations with reference to any future medical care.

MUST MEET THESE CONDITIONS

Voucher Form S-69 submitted by physicians must meet the following requirements: (a) All charges must be itemized to show specific dates on which treatments are rendered, the charge for each and a concise description of the injury for which the treatment is rendered. (b) *X*-ray charges must be itemized to show the dates on which made, number of views, parts of body *X*-rayed, and the charge for each service. (c) Joint accounts cannot be authorized for payment. If the services of an assistant or consultant is required, the assistant or consultant must submit a separate voucher. (d) Physicians and hospitals must not submit a combined account. Where the physician is owner or part owner of the hospital where the injured employee is treated, and the accounts are submitted in the physician's name or in the name of the hospital, a separate voucher should be prepared for each class of service. (e) Vouchers from physicians which include a separate charge for drugs must show whether such drugs were supplied from personal stock. If not, a receipted bill supporting the charge must accompany the voucher. All charges for drugs must be itemized.

SPECIFIC INSTRUCTIONS

The following specific instructions should be followed in submitting voucher Form S-69 for authorized hospital service. (a) Payment will be made for the day of admission but not for the day of discharge from hospital. Vouchers should be prepared accordingly. (b) The per diem rate for hospitalization includes all drugs, dressings and laboratory work. Payment for special drugs and supplies authorized by the attending physician will be approved. Whenever extra charges for special drugs or surgical supplies are made by a hospital, the kind of drugs must be shown on the voucher and if not supplied by the hospital, the amount claimed must be supported by a properly receipted bill. If not supplied from stock or supported by a receipted bill, the cost of the articles should not be included in the hospital voucher and druggist or firm supplying the articles should be instructed to submit a separate voucher. (c) *X*-ray charges must be itemized as described in the preceding paragraph. (d) Hospitals and physicians must not submit a voucher combining the services of both.

Each voucher Form S-69 must be supported by proper written authority for such service, unless such authorization has previously been forwarded to the Commission.

TRANSPORTATION EXPENSES

Necessary expenses incurred for the transportation of injured employees for the purpose of obtaining medical treatment may be submitted to the Commission on Form S-69 for direct settlement or reimbursement.

Blank forms for use in filing reports and claims will be furnished by the Commission to compensation officers.

The total aggregate compensation in any individual case shall not exceed $3500. The monthly compensation for disability shall be 66 2-3 per cent of the monthly wage received by the injured employee at the time of injury, but such compensation shall not in any event exceed the rate of $25.00 per month. The limitation on the aggregate amount which may be paid and on the monthly rate are exclusive of medical costs.

When death results from a traumatic injury sustained while in the performance of duty, reasonable burial expenses will be paid, subject to a maximum of $200 in any case.

ADMINISTRATIVE CHANGES AT INDUSTRIAL COMMISSION RECOMMENDED BY SHERRILL INVESTIGATORS; ADDITIONAL MEDICAL PERSONNEL AND BOARDS OF REVIEW ADVOCATED

NUMEROUS recommendations for changes in the administrative procedure of the State Industrial Commission, in the personnel employed by the Commission, and in the Ohio Workmen's Compensation Law itself, are contained in the report of the Sherrill Ohio Government Survey Commission.

The Sherrill Commission was appointed by Governor Davey in cooperation with various business groups of the state to survey the State Government and to make recommendations for greater economy and efficiency in its operation.

The Commission concluded its investigation a month ago and has been submitting its report in sections to the Governor.

The report on the State Industrial Commission, recently released, states that annual savings of approximately $233,693 can be made in the operation of the Industrial Commission and the efficiency of that department enhanced if the recommendations of the Sherrill investigators are adopted.

That part of the report dealing with the Medical Division of the Industrial Commission will be of particular interest to the medical profession of the state.

It points out that this division controls to a very large extent the amount and duration of awards on injuries, particularly the more serious ones and that "its efficiency is impaired on account of insufficient personnel that is trained and competent, because of inadequate and badly-arranged quarters, as well as other contributing causes which result in delays in the handling of claims".

The verbatim recommendations of the Sherrill Commission for changes in the Medical Division are as follows:

"(a) Replace the present Chief Medical Examiner, who is partially disabled, with a younger, more aggressive type who has executive ability and proven medical experience. The present incumbent should be assigned duties where his disability will not hamper the efficient operation of the Division. Increase the salary of the Chief Medical Examiner to $5,000.00 per annum.

"(b) Replace the present Assistant Medical Examiner, for reasons similar to (a) above. Increase the salary of this position to $4,000.00 per year.

"(c) Increase the salaries of the Medical Examiners from $2,600.00 to $3,500.00 per annum and replace those of the present force who, in the opinion of the new Chief Medical Examiner, do not qualify.

"(d) Employ twelve additional Medical Examiners and the necessary additional force to clear the present accumulation of claims; insist that current work be kept up to date.

"The additional expense is covered by the Survey's recommended appropriation, for which legislative action is required.

"(e) Appoint local Regional Medical Boards of Review to review and pass on chronic unusual or revived cases when reports by examining physicians show disagreement. Membership of these Boards not to be fixed but selected from lists of local specialists, well-qualified to pass on cases under consideration; payment to be on a per diem basis.

"(f) Continue the critical examination of medical and hospitalization bills, which resulted in a substantial reduction of expense in 1934.

"Illustrative of the economies possible in such a program is the 1934 performance as compared with 1932. If the charge rates for 1932 had obtained for 1934, the loss to the Fund would have been $1,758,845.00.

"Executive action required."

It will be noted that among the recommendations is that for the appointment of Regional Medical Boards of Review which has been advocated by the State Medical Association both in communications to the Industrial Commission and to other groups engaged in investigations of the Industrial Commission.

The recommendation for continued examination of medical and hospitalization bills especially that portion contrasting expenditures for 1934 with 1932, is vague.

The report does not show whether the investigating commission took into consideration the fact that a flat reduction of 20 per cent had been applied to medical bills during most of 1933 and all of 1934 as a temporary emergency measure.

The suggestion that "critical examination" of medical and hospitalization bills be continued is in line with previous recommendations of the State Medical Association which has pointed out on numerous occasions that unnecessary medical care and over-treatment can be minimized by more frequent and more careful investigation of claimants.

The recommendations for increased personnel in the Medical Division and the payment of higher salaries to medical examiners also conform to previous recommendations of the State Medical Association.

Among other interesting recommendations of the Sherrill Commission are the following:

1. Continuation of the present method of ap-

pointing members of the Industrial Commission but place the Secretary under Civil Service.

2. Changes should be made in the office layout and space which is now spread over four floors of the State Office Building.

3. Additional personnel should be employed in the ten field offices. A supervisor of field forces should be appointed, with headquarters in Columbus to supervise the field investigations. Up to 12 deputy commissioners should be appointed to assist in hearings; also additional payroll auditors.

4. A more adequate auditing system should be installed and greater use made of mechanical devices to provide checks and balances. A qualified assistant auditor should be appointed.

5. New procedure in the Claims Division, similar to that recommended for the Auditing Division should be installed. Superintendent of Claims should exercise more active and efficient control of his department. Reduction in personnel when increased efficiency is obtained from installation of new procedure.

6. An office manager should be named for the Legal Division. Provision should be made for the control of visitors and safeguarding of confidential information. Make use of stenotype machines in this division in taking notes on hearings. Prevent continuances whenever possible since they are among the cause of so many rehearings.

7. Merge the occupational disease fund with the other funds by combining the accident and occupational disease ratings. Establish January 1 and July 1 as common expiration dates on all risks.

8. The Legislature should provide adequate appropriations covering compensation for injured or disabled state employes, to pay deficits accumulated over a period of years. The deficit in the county portion of the Public Employes' Fund should be reduced more rapidly.

9. Liberalization of the type of investments in which funds can be invested.

10. Transfer of the Division of Safety and Hygiene to the Department of Industrial Relations.

11. Bill employers for premiums semi-annually.

12. Provide power of injunction restraining non-complying employers from further prosecution of business.

13. Require claims to be filed within one year instead of two.

14. Compensate partial loss of bodily member proportionate to total loss.

15. Require kind and degree of proof in hernia cases.

16. Provide for cases prolonged by prior injury or physical defect.

17. Require more substantial proof of status of persons claiming dependency.

18. Give Commission power to fix average weekly wage of injured employes.

19. Limit reopening of claims to two years.

20. Make Commission's findings final on all questions of fact.

To carry out the program recommended, the report recommends the following Legislative appropriations: 1935, $1,200,000; 1936, $1,442,800; 1937, $1,442,800; 1938, $1,142,800.

INCREASE IN ASSETS AND SURPLUS OF WORKMEN'S COMPENSATION FUND SHOWN IN RECENT REPORT OF CHIEF ACTUARY

SUBSTANTIAL increases in the assets and surplus of the Ohio Workmen's Compensation Fund took place during the calendar year 1934, according to the official report of E. E. Evans, chief actuary of the State Industrial Commission, on the status of the fund as of December 31, 1934, recently submitted to the Commission.

The assets of the fund increased from $39,093,-348.54 to $44,082,016.70, an increase of $4,988,-668.16 during 1934. This is the first year that the assets have increased since 1928.

The reserves set aside for future payments on pending and continuing claims and other obligations of the fund increased to $41,182,896.53, an increase during 1934 of $3,280,284.86.

During 1934, the surplus increased $1,037,-136.77, from $634,988.58 to $1,672,125.25, due to improvement in industry as reflected in increased payrolls, premiums and claims filed.

Mr. Evans made an unusually interesting report on claim costs for 1934, using the following tabulations as the basis:

CLAIM COST FOR YEAR 1934 DISTRIBUTED BY YEAR OF ACCIDENT OCCURRENCE

Private Employers' Accident Fund

Year of Accident Occurrence	Compensation	Medical	Total	%
1934	$1,869,403	$1,927,148	$3,796,551	32.4
1933	811,886	376,702	1,188,588	10.1
1932	729,747	132,916	862,663	7.4
1931	967,863	120,297	1,088,160	9.3
1930	1,078,444	98,559	1,177,003	10.0
1929	1,018,778	85,838	1,104,616	9.4
1928	658,271	54,029	712,300	6.1
1927	395,818	47,592	443,410	3.8
1926	230,617	42,836	273,453	2.3
1925	185,586	53,058	238,644	2.0
1912-1924	679,780	162,349	842,129	7.2
Total	$8,626,193	$3,101,324	$11,727,517	100.
%	73.56	26.44	100	

Commenting on the above figures, Mr. Evans said:

"The claim cost for the year 1934, on accidents

of all years, of private insured employers amounted to $11,727,517, of which $8,626,193, or 73.56 per cent was for compensation to the injured worker or his dependents; the remaining $3,101,-324, or 26.44 per cent was for physicians, hospitals, nurses, medicine, funeral and other benefits. It will be noted that only 32.4 per cent of the total cost in 1934 was for 1934 accidents and that over 50 per cent of the total cost during the year was for accidents that had occurred three years prior. On accidents that were ten years old or over there was required a total of $842,129, or 7.2 per cent of the total cost during the year.

"Over one-third of the total compensation cost in 1934 was for 1929, 1930 and 1931 accidents, clearly showing the heavy requirement for accidents of these three years. The accidents of 1930 required 10 per cent of the total cost as compared to the requirement of only 7.4 per cent for accidents of 1932, notwithstanding the fact that the accidents of 1930 were over three years old in 1934 while accidents of 1932 were only two years old. This discloses the tendency for accidents that occurred in the early period of the depression when the previous earnings of claimants established a high compensation rate, to continue for an unusually long period of time, while accidents occurring well into or during the latter part of the period of depression, when the previous wage earnings of claimants would not warrant a high compensation rate, show a tendency to more quickly terminate.

MEDICAL COSTS BELOW 1932

"Medical cost in 1934 on 1934 accidents is greater than that of compensation. This is accounted for by the fact that a large number of claims do not develop disability of more than one week, therefore, only medical benefits are payable in such cases. Approximately two-thirds of the medical cost is paid during the first year following accident occurrence, as the medical cost in subsequent years is only a fraction of the compensation cost.

"The average compensation and medical cost per claim increased in 1934 over that of 1933, both compensation and medical cost each showing an increase of 2 per cent above that of the previous year. However, when we compare the level of compensation cost in 1934 with that of 1929, we find that the compensation cost in 1934 was 4.2 per cent below and the medical was 6.3 per cent below the level of 1929. If we compare the 1934 average cost with that of 1932, when compensation and medical costs were at their peak, we find that the compensation cost in 1934 was 12.8 per cent below and the medical 25 per cent below that of 1932. In comparing the cost level of the various years, the cost during the year on claims of all years of accident occurrence was used."

The report contained the following tabulations of assets, liabilities, receipts and disbursements, payrolls, premiums, number of claims filed, etc.:

ASSETS AND LIIABILITIES OF FUND

ASSETS	Assets	Liabilities
Invested in Bonds	$34,230,173.97	
Bank deposits (inactive)	29,726.71	
Bank deposits (active)	4,160,627.78	
Premium in course of collection	4,155,883.95	
Accrued interest due fund	1,040,236.65	
Bond prem. after amortization	465,367.64	
LIABILITIES		
Reserve held to cover awards on which payment is required to be made over a period of years, or during the life of the injured worker		$37,369,358.58
Reserve to cover warrants issued but not cashed		483,355.95
Reserve for portion of advance premium payments not already earned		3,330,182.00
Due Public Employee Fund		1,226,994.82
Net Surplus, statutory and general		1,672,125.34
	$44,082,016.70	$44,082,016.70

COMPARATIVE RECEIPTS AND DISBURSEMENTS

Year	Receipts	Disbursements	Receipts	Disbursements
1929	$16,221,264.67	$16,282,539.08		$ 61,274.41
1930	14,004,755.54	16,165,029.67		2,160,274.13
1931	11,544,899.14	16,077,209.54		4,532,310.40
1932	8,140,584.09	14,406,006.65		6,265,422.56
1933	8,820,381.47	12,896,361.28		4,075,975.81
1934	14,510,777.24	12,210,370.67	2,300,406.57	
Total	$73,242,662.15	$88,037,516.89		$14,794,854.74

PAYROLL, PREMIUM AND CLAIMS FILED

Year	Payroll	Premium	Claims Filed
1929	$1,578,886,096	$13,274,966	234,314
1930	1,383,802,716	11,128,799	193,005
1931	1,118,587,184	8,958,868	154,232
1932	838,775,495	5,990,994	117,866
1933	787,633,213	6,906,666	117,002
1934	951,350,627	12,550,252	141,429

In his analysis of some of the foregoing figures, Mr. Evans said:

"The statutory and general surplus of the fund at the close of 1929 totaled $6,075,481.35, and at the close of 1932 was only $115,908.33, a reduction of $5,959,573.02 in the surplus for the three years 1930, 1931 and 1932 to meet the exceptional demand for compensation benefits. During these three years the reserves for claims were also reduced $7,971,813.50, from $46,778,588.50 to $38,806,775.00 in paying compensation and other benefits. The experience of these recent years has disclosed the necessity of maintaining adequate reserves and surplus to meet the abnormal trends in industry which greatly affects workmen's compensation cost.

"Ohio employers and employees have been fortunate as compared with other states in that no injured employee has lost his benefits due to lack of adequate insurance protection to meet such payments. In many states the employer is obligated to pay benefits to his injured employees if his insurance carrier is not in a position to do so. The Ohio State Insurance Fund has met its obligations through the recent years which have given workmen's compensation carriers the severest test experienced since the inception of workmen's compensation. Other states have been confronted with the problem of many injured employees losing their workmen's compensation benefits due to insurance companies going out of business. It is reported that in Pennsylvania

seventeen out of one hundred and seventy-five insurance companies have gone out of business since January 1, 1931, and now are unable to meet their legal obligation to injured workers, while in New York eighteen companies which had been placed in liquidation had a total workmen's compensation liability estimated at $2,600,000.

BIG INCREASE IN RECEIPTS

"Receipts increased 64.5 per cent during 1934. This is a sharp increase over 1933. However, it must be recognized that the receipts of 1933 were at a very low level, and the receipts for 1934 are only 3.6 per cent above 1930 and 10.5 per cent below 1929.

"Disbursements declined 5.3 per cent during the year but were only 25. per cent below 1929, a peak year of industrial activity. Disbursements do not fluctuate as widely when industrial conditions vary as do receipts, due in many cases to claim payments being required to be made over a period of years. Less than one-third of the disbursements in 1934 were for accidents occurring during the year, while over one-half of the disbursements were for claims on accidents occurring prior to 1932.

"The tendency of receipts to sharply fluctuate with industrial trends while disbursements maintain a more constant level causes each to vary widely from each other. In 1932 disbursements exceeded receipts by $6,265,422.56 while two years later we find the reecipts exceeding disbursements by $2,300,406.57. In high productive years when the accident frequency is high ample reserves must be set aside to meet future payments on claims; these reserves then provide for this wide fluctuation in receipts and disbursements.

"The Ohio State Insurance Fund, with its claim reserves of $37,369,358.58, is the largest carrier of workmen's compensation insurance in the country; its total annual workmen's compensation pure premiums and benefits paid exceed that of any other insurance company or state fund.

PAYROLLS AND PREMIUMS

"The payroll of insured employers for 1934 increased 20.8 per cent over 1933 but was still at a level of 39.8 per cent under 1929. Premium receipts increased 81.6 per cent but was still at a level of 5.5 per cent under 1929.

"Payroll and claims filed have maintained a very similar ratio to each other, as both payroll and claim frequently in 1934 were at a similar level above that of 1933 while each was also at a similar level below that of 1929.

"The premium shows a very substantial increase over payroll and claims. This increase is attributable in a large measure to the increase of rates on July 1st, 1933 of 28.8 per cent, which increase did not influence fully the premium receipts of an entire year until 1934. The rate level on July 1st, 1934 was not changed. A portion of the increase in premium over payroll is due to the revival of more hazardous industries which had suffered a greater retrenchment in activity during the depression. The fund has also made substantial collections of premium after investigations had disclosed that proper returns had not been made by some employers in past years. These cases have also served to influence the returns of some other employers who were making improper returns. The statutes provide for a substantial increase in the premium due where improper returns are found to have been made to the fund."

Mr. Evans' report mentions an amendment to the Workmen's Compensation Law enacted at the regular session of the 91st General Assembly which provides that the attorney general or any employer who has paid his premium into the fund may enjoin the further operations of any employer who has failed to comply with the Workmen's Compensation Act.

In announcing the annual revision of premium rates, the report states that the same general levels of 1934 are maintained for the year beginning July 1, 1935, pointing out that the total surplus is low when the volume of coverage provided by the fund is considered and is not at a point that would warrant a general decrease in the rate level.

—OSMJ—

Warning for Physicians Who May Be Planning Vacation Tour

A letter received recently by *The Journal* from Dr. S. J. Goodman, Columbus, Councilor of the Tenth District, contains a warning for Ohio physicians who are contemplating vacation tours.

Dr. Goodman wrote from Los Angeles following a tour of the Grand Canyon and other scenic attractions in that vicinity. He stated in his letter that although the tourist party had been guaranteed air-cooled cars, they were given accommodations in "a dirty, non-air-conditioned car, both ways" and that all members of the party "suffered terribly from the heat while crossing the desert". Dr. Goodman wrote that the party, including himself and family, "paid full fare with no reduction on account of the 'tour' ". He says the entire party has demanded that the railroad company return their Pullman fares.

Dr. Goodman writes that he felt it his duty to warn other Ohio physicians to be on guard against similar treatment in case they decide on vacation tours, and warns them to make certain that the railroad company offering the tour will provide the accommodations promised and expected by the tourists.

—OSMJ—

U. S. Public Health Jobs Open

The United States Civil Service Commission has announced open competitive examinations for public health specialists in the U. S. Public Health Service. These positions include several grades of bacteriologist, cytologist, epidemiologist and mycologist positions, and that of senior pathologist. The entrance salaries range from $2,600 to $4,600 per year. Applications must be on file with the U. S. Civil Service Commission, Washington, D. C., not later than September 9, 1935.

—OSMJ—

Richwood—Dr. Kenenth W. Keezer has opened offices here. Dr. Keezer was recently married to Miss Pauline Perry, R.N., Grant Hospital, Columbus.

MOVEMENT TO EXTEND RETAIL SALES TAX ACT TO SERVICES, INCLUDING MEDICAL SERVICES, GAINING MOMENTUM

WHEN the Ohio General Assembly will be called into special session and what its tentative program will be with respect to taxation were uncertainties as this issue of *The Journal* went to press.

Governor Davey has been quoted in the press as favoring a three- or four-day session in September to enact legislation to take care of the problems of poor relief and old age pensions for the rest of 1935 and deferring consideration of permanent tax legislation until after the November election.

Failure of groups backing three proposed Constitutional amendments on taxation to secure sufficient signatures to their petitions leaves directly in the hands of the Legislature the formulation of a permanent taxation program.

Regardless of when the Legislature convenes in special session, a number of the major taxation proposals that doubtless will be considered will be of direct concern to members of the medical profession, which must be prepared through the legislative machinery of medical organization to emphasize its views on taxation matters.

Although serious consideration is being given to a proposed income tax and possibly a gross receipts tax, sentiment for re-enactment of the Retail Sales Tax which expires December 31, 1935, is crystalizing and great pressure will be made on the Legislature to continue this act for at least another year.

In all probability strong efforts will be made to eliminate many of the present exemptions in the Sales Tax Law and to extend it to include "services" of all kinds, including professional services.

The following quoted from an article by the legislative correspondent of a Columbus newspaper is typical of the sentiment being expressed about the Capitol where the Joint Legislative Taxation Committee has been holding hearings for the past two months:

"A drive for the elimination of all exemptions and extension of the sales tax to include services is considered likely when the General Assembly comes back in special session to build its new tax program.

"Demands for poor relief, old age pensions and schools will necessitate millions in new revenue and the sales tax, it is believed, is the most reliable vehicle at hand.

"Under the broad extender plan talked among legislators, the sales tax would be applied to doctor bills, lawyer fees, hotel room rentals, shoe shines, haircuts, shaves, beauty operations and countless other services of a routine nature.

"Some of the items, now exempt, that would be taxed if all exemptions were eliminated are utility services (gas, electric and telephone bills), farm implements and farm products sold on the farm.

"It is doubtful whether the strong farm bloc, especially in the House of Representatives, will allow the tax advantages gained by the farmer to be wiped out without a bitter fight.

"Even if the sales tax could be made to yield an additional $25,000,000, it would not meet the demands as now estimated.

"Members of the Joint Legislative Committee on Taxation have fixed the need for new revenue for the remainder of 1935 and all of 1936 as high as $44,000,000 for old age pensions, poor relief and schools alone.

"It also is considered probable that an attempt will be made to abolish the present coupon system of collecting the sales tax.

"Several legislators have reported privately that their constituents are not at all satisfied with the "nuisance" of tax coupons and probably will ask them to support a measure doing away with the practice.

"There may even be a move inaugurated to make Ohio's tax a gross retail sales tax, which would better satisfy the consumer but which probably would not meet with the approval of the merchant.

"Friends of the coupon system argue that it is the surest way to keep both the consumer and dealer honest, and that it can be handled by the merchant with a minimum of trouble.

"Not only will the farm bloc oppose the elimination of exemptions, according to current reports, but it also will seek still further exemptions in behalf of the farmer. One thing that it is believed certainly will be asked is an exemption on the sale of farm products in urban markets."

Most physicians doubtless are opposed to the extension of the sales tax to include services. There are reasonable and logical arguments against applying the retail sales tax to medical services.

If this is done, physicians would have to become tax collectors; secure a vendor's license; and have to keep a rather complicated set of records for inspection by tax officials.

Obviously, many physicians' offices are not equipped to do this. Besides, the average physician is already over-burdened with paper work.

The most serious objection lies in the fact that in effect physicians would have to absorb the tax in many instances.

Theoretically, the physician would purchase the tax coupons and be reimbursed when the patient pays his bill and the tax.

However, the physician in all probability extends more credit and collects a smaller percent-

age of his accounts than any other vendor of services or merchandise.

Accounts are carried on the physician's books for months and years. On slow-paying accounts the physician would have considerable tied up in tax coupons for an indefinite period.

Where bills cannot be collected—and they are numerous these days—the physician would be out the amount paid out by him in purchasing the tax coupons.

If a merchant sells a piece of furniture, for example, on credit and pays the tax in advance for the purchaser, he can retrieve the article and sell it second-hand for enough to reimburse himself for the tax. The physician can not. He cannot retrieve the services he has rendered. If a patient does not pay his bill, the physician not only loses his fee but also the money he has advanced to purchase tax coupons.

Because of the humanitarian character of his work, the physician cannot refuse services to a patient simply because he refuses to pay the sales tax in advance. The merchant can, if he desires.

These arguments should be presented to members of the Legislature by their physician constituents. In addition it would be well to point out to legislators the fact that physicians have been rendering a tremendous amount of free services during the past four or five years and that it would be unjust at this time, particularly, to saddle him with taxes that cannot be passed on by him.

As pointed out previously, there is considerable sentiment for extension of the sales tax to services and it will require vigorous activity by physicians and other professional groups to prevent such an amendment to the sales tax law.

Local action is essential. Legislators should be seen immediately. Contacts should be formed with other groups which would be affected so that a united compaign can be waged.

As a matter of fact, some keen observers of the financial situation of the state and local governments have expressed serious doubt as to the necessity for any additional revenue-producing legislation. Figures relative to the needs of the state and local governments have been questioned by competent investigators who have pointed out that present revenues are sufficient if proper retrenchment and economy in government administration, both state and local, are carried out.

In line with this thought, physicians should take an active part in creating a sentiment among the electorate for curtailment of government spending and by all means against the enactment of additional taxes or extension of present tax laws.

—OSMJ—

Akron—Dr. Theodore W. Workman, 80-year-old retired Akron physician, was injured when attacked by a bandit.

How Physician Can Obtain Alcohol and Medicinal Liquor Under Amended Liquor Act

Sections of the Ohio Liquor Control Act governing the purchase of medicinal liquor and alcohol by physicians and others were amended at the recent regular session of the Ohio General Assembly.

While many of the amendments made in the act will not take effect until September 5, those referring to the various classes of permits *became effective June 5*, because they pertain to revenue-raising provisions. The Constitution of Ohio provides that all revenue-raising statutes take effect immediately following their approval by the Governor.

Through the cooperation of Isadore Topper, Assistant Attorney General and chief counsel for the Ohio Liquor Control Commission, information relative to the revised sections has been obtained, and is the basis for the following interpretation of the sections in which physicians will be especially interested:

Under the amended provisions of Section 6604-15 (now in effect) a retail druggist must obtain a G permit to be eligible to sell medicinal liquor, alcohol and wine. A holder of this permit may sell medicinal liquor in total quantities at each sale of not more than one quart and alcohol and wine in total quantities of not more than one gallon, upon the written prescription of a physician or dentist. *G permit-holders also may sell to a physician, alcohol in total quantities at each sale of not more than one gallon for use by the physician in his professional practice* and medicinal liquor in unlimited quantities to a physician for use in his practice.

Section 6604-15 also provides for the issuance of Permit I to wholesale druggists to be eligible to import and sell alcohol. Under the terms of this permit, *a wholesale druggist can sell alcohol in unlimited quantities to physicians*, retail druggists, dentists, hospitals, etc. However, in the sale of alcohol at retail, to non-professional persons, upon the written prescription of a physician, the wholesale druggist is limited to one quart at any one sale.

To summarize, a physician may obtain alcohol for professional purposes in unlimited quantities from a wholesale druggist who is an I permit-holder, and in quantities not exceeding one gallon from a retail druggist who is a G permit-holder. He may obtain medicinal liquor in unlimited quantities for use in his practice from a retail druggist holding a G Permit.

—OSMJ—

Wilmington—Dr. L. H. Senteff, superintendent of the Mt. Logan Tuberculosis Sanatorium, Chillicothe, recently addressed the local Rotary Club on the "History of Tuberculosis".

MEDICAL ECONOMICS--SOCIAL WELFARE--PROFESSIONAL, ORGANIZATION PROBLEMS

Stage is Set For Unusually Fine Annual Meeting

In this issue of *The Journal* is published the official program for the 89th Annual Meeting of the Ohio State Medical Association to be held Wednesday, Thursday and Friday, October 2, 3 and 4, at the Netherland Plaza Hotel, Cincinnati. This program deserves careful study.

Affected by the enthusiasm demonstrated by an unusually hard-working program committee, it seems to us that this program should convince any member that the Cincinnati meeting will be one of the most interesting and instructive in the history of the State Association.

Beginning with the clinics at Cincinnati hospitals on Wednesday morning and the first general session scheduled for 1:00 P. M. Wednesday, through the nine general sessions and the scientific sections, to the last scientific section on Friday afternoon, the program was designed to appeal to both general practitioner and specialist.

The program committee was especially fortunate in its selection of out-of-state speakers. Seldom is it possible to obtain so many nationally prominent speakers of recognized achievement in their respective fields as those scheduled for this year's meeting. An opportunity to hear such men as Dr. Frank H. Lahey, Boston, Mass.; Dr. James B. Herrick, Chicago, Ill.; Dr. Palmer Findley, Omaha, Nebr.; Dr. H. F. Helmholz, Rochester, Minn.; Dr. Wm. E. Sauer, St. Louis, Mo., and Dr. Sanford R. Gifford, Chicago, Ill., should not be passed up by members who are interested in keeping up-to-date in the progress of medical science.

The scientific sections, with gynecology added to the obstetrics section and a separate section in pediatrics this year, will be addressed by Ohio physicians especially qualified to discuss the important subjects selected.

In line with the Council's policy of using every available facility for the scientific development of the members of the State Association, one of the features of this year's Annual Meeting will be the scientific exhibit. It will be the most extensive ever presented at a state meeting.

The annual addresses of the President and President-elect will be presented at the general session on Wednesday evening, October 2. Dr. Morris Fishbein, editor of *The Journal of the American Medical Association*, will also speak at that time.

Cincinnati physicians are making elaborate plans for the entertainment of their visiting colleagues. The sand traps at Maketewah County Club will be ready for the medico-golfers on October 1. Hotel rooms are waiting to be reserved. (Note the list of Cincinnati hotel accommodations in the June and August issues of *The Journal*). The success of the Annual Meeting is now up to the individual members. It has been arranged for their education and enjoyment.

—OSMJ—

Criticism and Propaganda—There's A Difference

In a report recently made public, the Commonwealth Fund presents a critical analysis of the medical and hospital standards of rural sections of the nation.

The fund reports that in many rural communities there exists "a type of service which does credit to the profession and which carries within itself, in spite of numerous handicaps, the seeds of continuous progress".

In other parts of the country, the report declares, conditions are far from satisfactory, because in addition to able and conscientious physicians there are those of the type "who makes superficial examination, ignores the laboratory in diagnosis, relies overmuch on medication in therapy, neglects preventive measures, and subjects his patients uncritically to surgical interference".

Referring to innovations in the social and economic aspects of medical practice, the report says:

"The quality of the service rendered must be regarded as fundamental in any effort to evaluate either the existing organization of medicine or the suggested alternatives. Speaking broadly, any system of medical practice must stand or fall by the safeguards it throws about the patient, the degree to which it encourages professional growth, its effect on both the leaders and the stragglers in medicine".

At first glance, the average physician doubtless is inclined to take offense at this frank criticism of the profession and label the report propaganda for the socialization of medicine.

A more careful analysis may soften any indignation accruing in the first instance.

If able to forget for a moment the natural suspicion which exists on the part of the medical profession with respect to the activities and



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policies of many philanthropic and uplift groups, most physicians we believe will agree that the standards of medical practice not only in rural communities but throughout the country generally, are not perfect and should be improved.

We believe most physicians recognize that there are members of the profession who are within the scope of the criticism made in the fund's report.

The medical profession itself believes the quality of service and the interests of the patient are fundamental and must be given primary consideration in the formation of any and all methods of providing medical care.

The increasing need of adequate facilities for post-graduate instruction and ways of keeping the practitioner in step with advances in the science and art of medicine is not imaginary. The leaders in medicine are endeavoring in every possible way to stimulate an active interest on the part of the profession in educational programs designed to enhance the knowledge and competence of the man in active practice.

Before it protests too vigorously criticism by those outside the profession, the profession should stop, look and listen.

Physicians are justified in objecting to exploitation and publicity based on ulterior motives. At the same time, they should not become so biased that they refuse to weigh carefully the observations of other groups, some of which deal with the very problems for which the medical profession itself is seeking a solution and are based on factional data.

Short-sightedness on the part of the profession in this respect is just as inexcusable as short-sightedness on the part of the individual physician who refuses to keep in step with his colleagues in their effort to improve themselves and their service to the public.

—OSMJ—

Attendance of Delegates at Cincinnati Annual Meeting Essential

It would be timely for every component county medical society of the State Association to make an immediate check to determine if its duly elected delegate and alternate (or delegates and alternates) are preparing to attend the 89th Annual Meeting of the Association at Cincinnati, October 2, 3 and 4.

The first session of the House of Delegates will be held on the afternoon of the first day of the meeting.

Every county medical society should be properly represented at this session, as well as the second, and final, session scheduled for the morning of the last day.

Needless to say, business matters of importance to the entire membership of the State Association and the profession generally, will be considered

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by the House of Delegates. The collective views and opinions of the membership will be of value in these proceedings. They should be presented through the elected representatives of the component county societies.

The activities of the State Association are controlled by the policies laid down by the House of Delegates which are the result of the actions of those representing the organized profession in every community of the state.

Therefore, the importance of 100 per cent attendance at the sessions of the House of Delegates is obvious.

The members of each county medical society expect the society to be represented in the House of Delegates, as permitted under the Constitution and By-Laws of the State Association, and should insist that its official delegate or alternate attend.

—OSMJ—

High School Debaters Should Have Your Help and Cooperation

Physicians in different sections of the state have in recent weeks received requests from High School students, school librarians, etc., for suggestions as to sources of material on the subjects of sickness insurance, state medicine, and similar issues.

In some instances these requests have been forwarded to the State Association Headquarters

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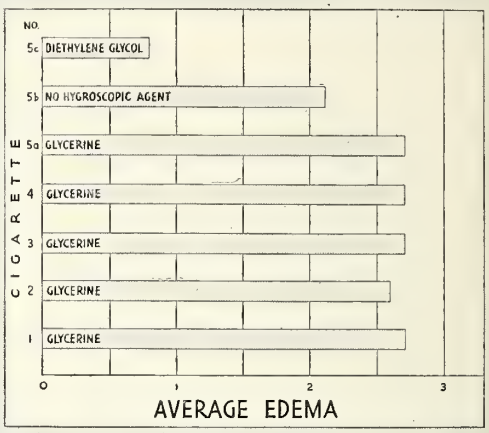
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Office for reply and the desired information has been sent.

This is a matter of unusual importance and it is hoped that every physician receiving requests of this character will promptly acknowledge them, furnish the desired information, if possible, or communicate with the State Headquarters Office, or the American Medical Association.

Considerable accurate information on these subjects is available in the files of the State Association and especially at the Bureau of Medical Economics of the American Medical Association which is making a special effort to supply high school debaters with comprehensive digests of discussions on sickness insurance, etc.

The medical viewpoint should be properly and accurately presented in debates of this character and it is the duty of the medical profession to make this possible.

Medical organizatiton should, and can, perform a public service by keeping in close touch with students, school officials, and others interested in discussions of medical economic questions and making itself the source of information. Individual physicians must do their part by referring inquiries to the proper sources, if unable to supply the information direct.

—OSMJ—

Soviet Medical Service OK for Others, Not Him, Mr. Filene Decides

The following article under a Moscow dateline was disseminated early in August by the United Press Service and published in many leading American newspapers:

"Edward A. Filene, Boston merchant and philanthropist, was gravely ill of pneumonia today. His condition was considered so serious that Dr. Fritz Meyer, German specialist, was summoned by airplane from Berlin."

Subsequent dispatches stated that Mr. Filene had rallied. Supposedly he is now out of danger.

Naturally, it is hoped that Mr. Filene will make a complete recovery. He is an estimable gentleman and good American citizen.

However, it is interesting to note that Mr. Filene (or his friends in Moscow) chose to ignore the mechanized medical service established by the Soviet Government and which has frequently been hailed by Mr. Filene and some of his associates as something which America should imitate.

If the clinics and the system of governmental medicine of Russia are good enough for the public generally, surely they should be adequate to meet the needs of those of wealth and prestige!

Apparently Mr. Filene and his friends did not think so.

It is not difficult to agree with them and, to go a step farther, observe that doubtless Soviet Russia's system of medical service is not the kind of service which even the lowly peasant would choose for himself, if he had the right to do so.

—OSMJ—

Akron—Dr. Horace E. Groom has been promoted from the rank of captain to major in the Ohio National Guard. He will command the hospital battalion of the 112th medical regiment.

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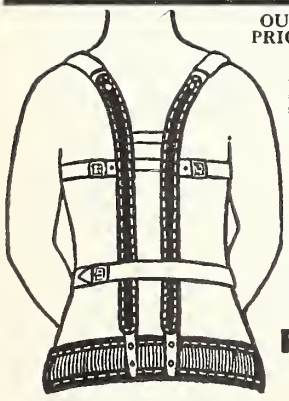
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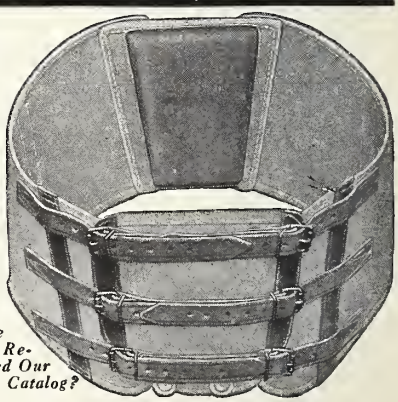
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DEATHS IN OHIO

William Altman, M.D., Cleveland; Ohio State University, College of Homeopathic Medicine, 1916; aged 48; former member of the Ohio State Medical Association and the American Medical Association; died July 16, following a short illness. He is survived by his sister and two brothers.

Frank M. Barden, M.D., Hamilton; Medical College of Ohio, Cincinnati, 1890; aged 71; former member of the Ohio State Medical Association and former Fellow of the American Medical Association; died July 25. Dr. Barden practiced in Hamilton for 45 years, retiring three years ago. He had been in ill health for about a year. He was a past president of the Butler County Medical Society. Dr. Barden took a keen interest in civic affairs. He was a director of several financial institutions, and an active member of the Masonic order. Surviving are two daughters, a sister and a brother.

Evan C. Brock, M.D., Columbus; Starling Medical College, Columbus, 1904; aged 54; former member of the Ohio State Medical Association and former Fellow of the American Medical Association; died August 15, of heart disease. Dr.

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William Daus, M.D., Cleveland; Western Reserve University School of Medicine, Cleveland, 1884; aged 73; died July 11, following a stroke. Dr. Daus practiced in Cleveland for 51 years. Surviving are four sons, two daughters, a sister and a brother.

Byron C. Eades, M.D., Conneaut; University of Michigan Medical School, Ann Arbor, Michigan, 1900; aged 59; member of the Ohio State Medical Association and Fellow of the American Medical Association; died July 29, after a six months' illness of heart disease. Dr. Eades was in active practice in Conneaut for 35 years. He was an ardent lover of outdoor life and prominent in the civic life of the community. He was a member of the Masonic and Elks lodges. Surviving are his widow and two sons, one of whom is Dr. Charles C. Eades, Detroit, Michigan.

Thomas H. Forster, M.D., Amelia; Medical College of Ohio, Cincinnati, 1897; aged 92; died August 9. Dr. Forster practiced in Cincinnati for 28 years, moving to Amelia upon his retirement 10 years ago. He was a veteran of the Civil War and a member of the Masonic Order. His widow survives him.

W. A. Held, M.D., West Unity; Chicago Homeopathic Medical College, 1897; aged 67; former member of the Ohio State Medical Association and the American Medical Association; died August 11, following a stroke of paralysis. Dr. Held practiced at West Unity for 38 years, and at the time of his death was Williams County health commissioner. Surviving are his widow, a son and two daughters.

Mary Lemmon, M.D., Cadiz; Cleveland University of Medicine and Surgery, 1893; aged 76;

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Masonic Temple, Detroit, Mich. OCTOBER 14-15-16-17-18, 1935

Pre-assembly Clinics, October 12; Post-assembly Clinics, October 19, Detroit Hospitals

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W. Wayne Babcock, Philadelphia, Pa.
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David P. Barr, St. Louis, Mo.
Alexander W. Blain, Detroit, Mich.
Harlow Brooks, New York, N. Y.
Alan G. Brown, Toronto, Canada
The Hon. Herbert A. Bruce, Lieut.-Gov. of Ontario, Toronto, Canada
Hugh Cabot, Rochester, Minn.
Russell L. Cecil, New York, N. Y.
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Arthur C. Christie, Washington, D. C.
Louis H. Clerf, Philadelphia, Pa.
Frederick A. Coller, Ann Arbor, Mich.
George W. Crile, Cleveland, Ohio
Harold B. Cushing, Montreal, Canada
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Waltman, Walters, Rochester, Minn.
William H. Wilmer, Washington, D. C.
Hugh H. Young, Baltimore. Md.

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Professor Nikolaj Burdenko, University Surgical Clinic, Moscow, USSR.
Professor N. Krasnagorski, Children's Clinic, Medical Institute, Leningrad, USSR.

TENTATIVE:

Professor Alfred Luger, Medical Department, University of Vienna, Vienna, Austria.

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died July 23 following a stroke. Dr. Lemmon practiced in Cadiz for 40 years. She was a member of the Methodist Church. She is survived by a brother, Dr. William H. Lemmon, and a sister.

William P. Love, M.D., Youngstown; Western Reserve University School of Medicine, Cleveland, 1896; aged 65; member of the Ohio State Medical Association and the American Medical Association; died July 12. Dr. Love served as major in the Medical Corps during the Spanish American War. He was surgeon-general of the United Spanish-American War Veterans, and was a member of the Association of Military Surgeons of the United States. In 1913 he left private practice to re-enter the military service, and was commander of the Third Field Hospital during the Mexican border trouble in 1916 and 1917. At the outbreak of the World War he organized a regiment of infantry to complete the 37th Division. He was a member of the Masonic Lodge, the American Legion and the First Baptist Temple. Surviving are his widow, a son, a daughter and a sister.

Frank H. Mohrman, M.D., Lakewood; Cleveland College of Physicians and surgeons, 1910; aged 48; member of the Ohio State Medical Association and Fellow of the American Medical Association; died August 2, following a heart attack. Dr. Mohrman was on the staff of St. Luke's Hospital. He was a member of the Masonic Lodge. His widow survives him.

Clyde L. Vorhies, M.D., Cambridge; Ohio State University College of Medicine, 1911; aged 48; member of the Ohio State Medical Association and the American Medical Association; died July 26, at St. Louis, Mo., of tuberculosis. Dr. Vorhies began the practice of medicine in Cambridge with his father, Dr. E. E. Vorhies, in 1911. They were associated together until his father's death in 1934. Dr. Vorhies was health commissioner of Guernsey County for 10 years. He was a member of the Masonic Lodge and the Methodist Church. Surviving are his widow, a son, and a brother.

D. K. White, M.D., Cleveland; Western Reserve University School of Medicine, Cleveland, 1886; aged 70; died July 15. Dr. White practiced at Richmond before moving to Cleveland. He is survived by his widow and a brother.

—OSMJ—

Athens—Dr. C. R. Hoskins, recently of the Manhattan, Eye, Ear, Nose and Throat Hospital, New York, has become associated with Dr. T. A. Copeland here.

Warren—Dr. Frank G. Guarnieri has opened offices here.

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COUNTY SOCIETIES *and* ACADEMIES

First District

Clinton County Medical Society held a round-table discussion of the probable causes and methods of treatment of summer grippe at its regular monthly meeting held Tuesday, August 6, at the New Martin Hotel, Wilmington.—Elizabeth Shrieves, M.D., Secretary.

Second District

Greene County Medical Society met in the courthouse, Xenia, Thursday, August 1. Dr. Walter M. Simpson, Dayton, discussed "Fever Therapy", and illustrated his subject with motion pictures.—News Clipping.

Fourth District

Ottawa County Medical Society held its midsummer meeting Thursday, July 11, at Marshall's Inn, Danbury. Dr. John H. Murphy, Toledo, was the speaker.—News Clipping.

Fifth District

Geauga County Medical Society met at Burton, Wednesday, July 31. "Scarlet Fever" was discussed informally by the members, and a case, complicated with measles, which proved fatal, was reported.—Isa Teed Cramton, Secretary.

Medina County Medical Society was addressed by Dr. C. E. Ward, Cleveland, on "Hernia", at a meeting Thursday, July 18, at Evanon.—News Clipping.

Sixth District

Mahoning County Medical Society held its annual picnic, golf tournament and field day at the Youngstown Country Club, Thursday, July 25.—Bulletin.

Stark County Medical Society held a golf tournament at the Shady Hollow Country Club, Massillon, Wednesday, July 31.—News Clipping.

Wayne County Medical Society held a picnic for families of the members at the Apple Creek Institution for Feeble Minded, Friday, July 26.—News Clipping.

Eighth District

Fairfield County Medical Society met at the Hotel Martens, Lancaster, Tuesday, August 13. Dr. R. H. Kissane, Columbus, was the guest speaker.—News Clipping.

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Prompt and Full Report

Guernsey County Medical Society, meeting Thursday noon, August 1, at the Berwick Hotel, Cambridge, was addressed by State Senator Willard D. Campbell on the subject of "Medical Legislation".—News Clipping.

Tenth District

Crawford County Medical Society held a golf tournament, Wednesday, July 31, at the Galion Country Club. A meeting was held in the evening at the home of Dr. H. W. Todd, Galion.—News Clipping.

—OSMJ—

Work Started on New A. M. A. Directory —Please Cooperate

The work of revising and compiling the new Fourteenth Edition of the American Medical Directory has been started.

After every directory is published, the American Medical Association receives complaints from some physicians who have not been listed as members or Fellows of the American Medical Association and as a result have lost business from industrial firms, insurance companies, railroads, etc. They may have been former members who have let their membership lapse or newly licensed physicians who have failed to join their local society in time to have this information inserted in the directory.

In order that members be properly listed, it is essential that they carefully and promptly comply with the request for data which they will receive from the American Medical Association. Members who have become delinquent should pay their dues at once to avoid losing their membership listing in the new directory.

The American Medical Directory is an unequalled source of valuable information concerning physicians, hospitals, medical schools, state medical boards, special medical societies, etc. It is used extensively by hospitals, insurance companies and industrial officials. It gives medical directors and chief surgeons practically all the data needed for choosing examining physicians in all localities in the United States and Canada.

The directory probably will not be published again until 1937 or 1938. It is therefore highly important that physicians take advantage of a complete and authentic listing in the edition now being compiled.

—OSMJ—

Columbus—A motorized nurse bed controlled by either cords or push-buttons, enabling the occupant to change positions with a minimum of effort, has been invented and is being marketed by Dr. C. E. Sharp. Planned especially for cripples, convalescent, aged and sick persons, it is designed to aid in the prevention of bed sores, static congestion and over-exertion.

Harlem Springs—Dr. Leora Perry Dahlgren, formerly superintendent of the Kingwood Sanitarium, Kingwood, W. Va., is now practicing here.

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NEWS NOTES *of* OHIO

Columbus—Announcement has been made of the marriage of Dr. N. E. Lenahan and Miss Ernestine Little.

Cleveland—Dr. Harold N. Cole, Western Reserve University, has been chosen as one of the United States delegates to the Ninth International Conference on Dermatology in Budapest, September 13-21.

Cuyahoga Falls—Dr. H. M. Platter, Columbus, secretary of the State Medical Board, was guest speaker at a recent meeting of the local Rotary Club, of which Dr. R. A. Burroughs, is the newly-installed president.

Cleveland—Dr. Henry J. Gerstenberger, professor and head of the department of pediatrics, of the School of Medicine, Western Reserve University, is in Leningrad, Russia, attending the International Physiological Congress.

Cleveland—Dr. Howard Dittrick, School of Medicine, Western Reserve University, will represent the United States government at the Tenth International Congress on the History of Medicine at Madrid, Spain, September 23-29.

Logan—Nearly 45 physicians from all parts of Ohio and other states attended the annual reunion of the class of 1897 of the Ohio Medical College which was held here recently at the home of Dr. J. S. Cherrington.

Magnolia—Dr. E. Ransom Koontz has accepted a position in the Bureau of Legal Medicine and Legislation of the American Medical Association. Dr. Koontz, who is a lawyer as well as a physician, just completed a surgical residency at City Hospital, Cleveland.

Galion—Dr. Herman H. Hartmann, who was defeated for mayor two years ago after having served 20 consecutive years in that post, was again nominated at the Democratic primary election, August 13.

Youngstown—The Speakers' Bureau of the Mahoning County Medical Society reports the following radio addresses by Youngstown physicians during the month of July: Dr. J. B. Nelson, "A Growing Menace"; Dr. F. W. McNamara, "Cancer is Curable"; Dr. Wm. M. Skipp, "Appendicitis Facts"; and Dr. M. E. Hayes, "Highway Hazards".

Cleveland—Dr. William H. Humiston, president of the Ohio State Medical Association in 1897-98, recently celebrated his eightieth birthday. Dr. Humiston retired in 1925, and now resides in Willoughby.

Gallipolis—Colonel Serge Androp, flight sur-

Kreemex Pancake Flour
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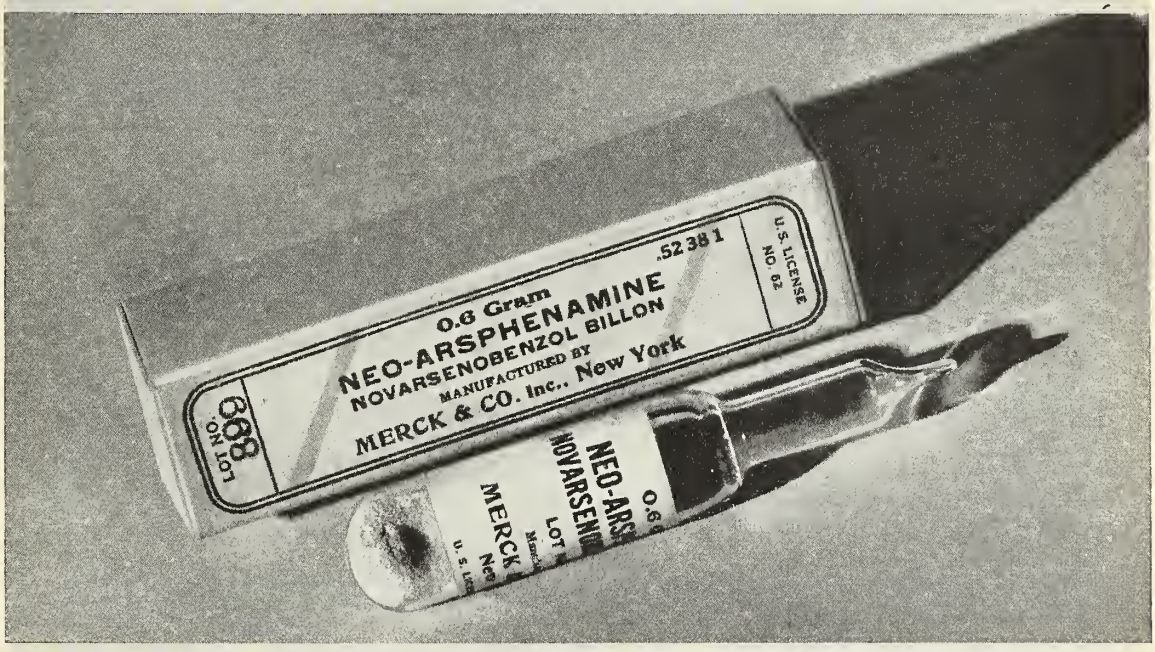
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geon for the Fifth Corps Area, U. S. Army, with headquarters at Fort Hayes, Columbus, and in civilian life, a member of the staff of the Ohio Hospital for Epileptics, was recently honored with a dinner given by Dr. C. E. Holzer, owner of the local airport.

Martins Ferry—Announcement has been made of the marriage of Dr. James H. Carson and Miss Esther Horswell.

Fremont—A Medical Service Bureau has been organized to facilitate the location of physicians. Dr. J. C. Boyce has been named temporary chairman and Dr. Carl Wolfe, secretary.

Marion—Dr. A. A. Starner, who was seriously injured in an automobile accident near Springfield, June 5, is convalescing.

Ansonia—Dr. C. J. Poling, veteran Darke County physician, has announced his retirement because of ill health.

Youngstown—Dr. D. H. Smeltzer was recently married to Miss Florence Buehrle.

Youngstown—Dr. Saul J. Tamarkin passed the examination of the American Board of Radiology.

Sandusky—Dr. R. E. Taylor, first lieutenant in the medical reserve corps of the U. S. Army, has been appointed to the medical staff of the Fifth Corps, Ft. Hayes, Columbus. After a short stay at Fort Hayes, Dr. Taylor will be transferred to a C.C.C. camp.

Wooster—Dr. L. G. Strauss has opened offices here.

Bellevue—Dr. C. L. Gray, who formerly practiced in North Fairfield, has opened offices here.

Ansonia—Dr. Donald G. Carlson, formerly of Columbus, has located here.

Cleveland—Dr. Charles F. Good has been appointed physician for the Nursery School at Western Reserve University, succeeding Dr. Joyce I. Hartman, who has been appointed supervisor of health education for the Cleveland public schools, remaining, however, as medical consultant for the Nursery School, together with Dr. Good.

Wilmington—Dr. Robert Conard spoke on "The Miracle of Health", at chapel services held recently at Wilmington College.

Bolivar—Dr. Leslie P. Haefele, formerly of Cleveland, has opened offices here.

—OSMJ—

CLASSIFIED ADVERTISEMENTS

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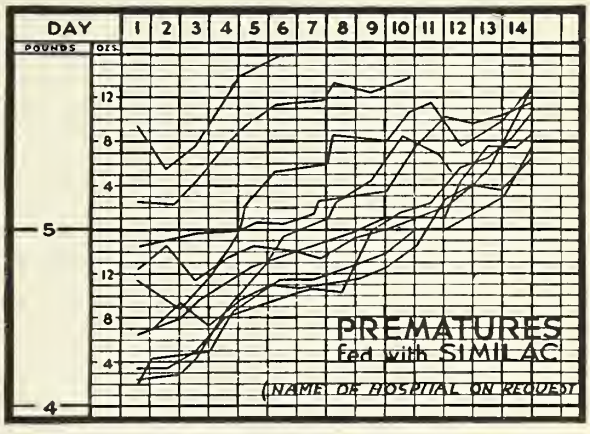
The observations referred to covered only three prematures fed on different fats, but showed an average of 78.4% retention for olive oil as compared to only 52.5% retention for butter fat.

*Holt, Tidwell and Kirk, Studies on Fat Metabolism in Infants—Acta Pediatrica. Vol. XVI, 1933.

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THE OHIO STATE MEDICAL ASSOCIATION
AS A MEDIUM OF SERVICE TO ITS MEMBERS

OCTOBER 1, 1935 VOL. XXXI Number 10

LAST CALL, 89th ANNUAL MEETING

NETHERLAND PLAZA, CINCINNATI, OCTOBER 2, 3 AND 4

The Annual Banquet, principal social event to be held during the 89th Annual Meeting of the Ohio State Medical Association, Netherland Plaza, Cincinnati, Wednesday, Thursday and Friday, October 2, 3 and 4, will be held on tbe evening of Thursday, October 3.

The guest speaker at this occasion, sponsored by the Cincinnati Academy of Medicine, will be Dr. Gordon J. Laing, Chicago, dean of the Division of Humanities, University of Chicago.

His subject will be: "Are Doctors Human?"

Dr. Laing, an educator of international reputation and an author who enjoys great popularity in educational circles, also is recognized as one of the most clever and entertaining after-dinner speakers of the country and one whose services constantly are in demand.



DR. GORDON J. LAING

The Banquet Committee of the Cincinnati Academy is pleased at its good fortune in being able to secure Dr. Laing to top-off the annual dinner program.

Dr. A. Graeme Mitchell, Cincinnati, will preside at the banquet.

Preceding Dr. Laing's address, the Hon. Russell Wilson, mayor of Cincinnati, will officially welcome Ohio physicians to the Queen City and Dr. Jonathan Forman, Columbus, will present, "Highlights of the First State Medical Meeting Held in Ohio One Hundred Years Ago".

Sale of tickets for the banquet will be conducted by the Banquet Committee, composed of Dr. Louis Feid, Jr., chairman, Dr. Francis E. Cunningham, Dr. Hugh H. Hengstenberg, Dr. Daniel C. Rivers, and Dr. Emil Swepston.

* * * * * * *

ANNUAL REPORTS OF COMMITTEES OF STATE ASSOCIATION AND SCHEDULES OF SCIENTIFIC EXHIBITS AND HOSPITAL CLINICS WILL BE FOUND IN THIS ISSUE

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Vol. XXXI OCTOBER, 1935 No. 10

CANCER OF THE ESOPHAGUS

By FRED W. DIXON, M.D., CLEVELAND, OHIO

PREVALENCE

CANCER of the esophagus is much more common than we are inclined to believe. It constitutes from 5 to 10 per cent of all cancers found in man. When we consider that there die annually in the United States and Canada 150,000 cases of cancer, we realize that approximately 10,000 cases die from cancer of the esophagus each year. The last report by the American College of Surgeons on those cases of cancer cures five years and over, in 24,448 cases listed as cured not a case of cured esophageal cancer was included. It is much more common in males than in females, the ratio given by most writers is five to one. The ages range from fourteen to ninety years. However, most cases here as elsewhere in the body occur after forty.

ETIOLOGY

In regard to the *etiology* of cancer at the present time the foremost theory is that of chronic irritation, such irritation may be either mechanical, thermal or the irritation of chronic infection, or what to me seems most logical, a combination of these. Those who hold the mechanical theory point to the fact that cancer occurs most commonly in those regions where the constrictions are found. Here the food is most likely to lodge, set up an irritative process with the formation of leukoplakia which is later followed by degenerative changes. Those who hold the thermal irritative theory point to China where the men eat first while the food is hot. Cancer of the esophagus here is unknown in women.

In the presence of carious teeth, the mouth, larynx and pharynx hold the most virulent bacteria in the body. It is possible that given an abrasion on the lining membrane of the esophagus these bacteria gaining entrance might set up an extremely irritative process.

Heredity, rapidity of eating, coarseness of food seemed to play no part in its occurrence. About one-third of my cases drank in moderation, while one-half had carious teeth.

LOCATION

The location of the growth is usually found at one of the constrictions, thus lending color to the theory that irritation is one of the predisposing factors. The three sites of such narrowing are the entrance to the esophagus, at the level of the tracheal bifurcation and at the cardiac end of the esophagus, where it passes through the diaphragm. In males the most common location is in the middle and lower third. While in women the upper third is more commonly involved.

Author	*Location*			*Total*
	Upper	*Middle*	*Lower*	
Vinson	162	397	441	1000
Klein-Von Hacker	50	159	93	302
Lotheissen	24	88	68	180
Kraus-Ridder	469	519	760	1748
Clemmison-Monkhouse	6	55	28	89
Clayton	4	19	14	37
McCullogh	18	30	34	82
Andersen	6	5	11	22
Present Series	13	16	16	45
	752 (21.5%)	1288 (37%)	1465 (41.5%)	3505

Read before the Eye, Ear, Nose and Throat Section, Ohio State Medical Association, at the 88th Annual Meeting, Columbus, October 4-6, 1934.

PATHOLOGY
(Type and Metastasis)

Pathologically these are generally classified into two types, (1) sarcoma which is rarely found (only about 40 cases in all the literature), (2) carcinoma which is the common type. Usually they are the squamous cell or transitional adenocarcinoma. *Macroscopically* the same three types of growth occur here as elsewhere in the alimentary canal, namely, the proliferative or cauliflower type, the ulcerative type with a hard edge and indurated surroundings, and thirdly the schirrhous type with early narrowing and deformity. The first one mentioned is probably the least malignant. The spread of the cancer may be by direct extension, by the lymphatics, or the blood stream. When direct extension does occur the structures involved depend upon the location of the growth. At the upper third the larynx and thyroid, in the middle third the aorta and trachea while the lower third abdominal extension frequently takes place. Most authors are in agreement that metastasis does not occur early. Helsley in an analysis of seventy cases carefully examined postmortem with regard to glandular involvement and metastasis, found that in 64 per cent the carcinomatous condition was confined to the esophagus. The local lymph nodes were involved in only 6 per cent while the remaining 30 per cent showed distant metastasis to lymph nodes and other vicera. The average duration of symptoms in Helsley's cases was five months. It is obvious then that had these cases been operated upon early very few would have invaded beyond the esophagus itself. The type of growth is probably the determining factor in the rapidity of its spread.

SYMPTOMS

The warning symptoms of cancer of the esophagus are extremely vague and uncertain and account for the fact that these cases do not come in early. The patient may complain of an odd sensation in the swallowing act and of a lump rising in the throat, even though there is no interference with the passage of food. Some patients come in with the primary symptoms of loss of weight or loss of appetite. In my cases the most common symptom which brought them in for aid was *difficulty* in swallowing. On closer questioning they admitted that preceding this there was a burning sensation or discomfort either behind the sternum or between the scapulae. These symptoms were commonly termed "sour stomach" and ignored from four to six months before the first visit. In my series of cases the length of time elapsing from the time the symptoms were first noted until a doctor was consulted was five months. Dysphagia or painful swallowing is often a late symptom. Cabot states that in four cases out of twenty pain was not present up till the time of death.

In a patient over forty, especially if it be a male previously free from digestive disturbances, complaining of the slightest difficulty in swallowing, the possibility of cancer of the esophagus must be considered and further investigation undertaken. Of the constitutional symptoms, loss of weight is most marked. This is due partly to lack of nourishment and partly to lack of water. This leads to extreme thirst, scanty urine, skin becomes dry but the typical look of the cancer case is absent due to the rapidly fatal termination before this has time to develop.

If the phrenic and vagus nerves are impinged upon, hiccoughing, occasionally suffocative attacks are experienced. If the recurrent laryngeal nerve is caught, hoarseness will result. Bloody expectorations, foul breath, black coated tongue are late symptoms.

DIAGNOSIS

Our two most valuable aids in diagnosis are the *X*-ray and the esophagoscope. A mouthful of barium emulsion is given and with the aid of the fluorescent screen is observed as it makes its way into the esophagus. Special reference is made to the size of the lumen, presence of any obstruction, its size, site and degree. Later, a permanent radiogram is made. Our other reliable aid in diagnosis is the esophagoscopic examination. By this means the amount of extension, the shape and kind of growth can be ascertained. Flexible bougies may be passed to determine the amount of obstruction. Also in this manner tissue for a biopsy can be taken to determine if the growth is benign or cancerous and if cancerous the direction of metastasis and the degree of malignancy. If a radical removal of the esophagus is contemplated bronchoscopic examination is also indicated for if there is an involvement of the trachea and surrounding structures no operation can be successful.

TREATMENT

Consideration of the treatment of this condition inspires no great hope at present, yet some of the greatest achievements of medicine have presented as insurmountable tasks. In the ladder of "successful treatment" the first round must be early diagnosis. An educated public awakened to this fact is essential. So also must we rely more on the roentgenologist and the esophagoscopist and less on the inferential guess of "globus hystericus" and "spasm". Only then will this disease, insidious in its onset, relentless, remorseless in its course, and finally fatal in its issue, yield to brilliant results.

Prophylactic treatment is of little value save that in those cases of stricture or obstruction they should be kept under observation so that should cancer occur, early treatment could be instituted.

Where the cases have developed, diet is of the utmost importance. The food should be thoroughly cooked and non-irritating. An abundance of vegetables should be given. All should be passed through a sieve of number 25 mesh. Milk should not be given at or near the same time as curd producing foods for this will obstruct a small tortuous lumen. Rectal feedings save in the form of glucose are of little value. One of my patients tolerated a soft rubber tube by mouth for several weeks. However, the time came when food would not any longer pass through.

Drugs have a very important part in that while we cannot prevent the passing of these unfortunates, we can make them more comfortable. Beginning at first with milder sedatives we pass to the stage where only morphia gives relief. Often cocaine $\frac{3}{00}$ ¼ or ½ per cent given before meals is helpful. Radium has been tried and some writers have reported very favorably. An esophageal catheter is taken and the appropriate dose of radium sewed into the tube. By means of the fluroscope this tube is passed to the level of the growth and allowed to remain until adequate dosage is given. Jackson is disappointed with radium. Guisiz's reports are more favorable. In 1924 he reported 270 cases with almost complete obstruction in which life was prolonged from three to sixteen months. My own experience with radium has not been extensive. I have tried it in two cases; one where the growth was small and easily accessible at the entrance to the esophagus; he is comfortable and working after twelve months. The growth has almost disappeared and he is gaining in weight. The other where the growth was extensive produced no benefit.

If one can see these cases early I believe something can be gained. Dilatation is extensively used in the Mayo Clinic. A silk string is given the previous day and the dilator is passed over this string the next morning. This is followed with relief in taking of food. This, of course, has to be repeated at weekly intervals and is not without certain risk of tearing the esophagus. One case I had which lived by dilatation for eight months working in comfort up until one month before his death. It is extremely difficult to see these cases gradually failing and not be able to help them. It is for these inoperable cases when only liquids are passing that gastrotomy is to be considered. In these cases feeding directly into the stomach often prolongs their life in comfort many months. The operation should be done while the patient's resistance is good and if carefully performed is almost devoid of risk. With the feeding through the gastrotomy tube the inflammation and spasm in the esophagus subsides and water is once more taken by mouth. Many patients, however, become pessimistic, feeling that since it is only a question of time and that the joy of eating is gone, permission to operate will not be given. Some of the most encouraging reports have come from early deep Roentgen therapy. The actual *X*-ray beam is carefully measured and directed through several portals of entry at the growth. By cross firing these beams from three to six weeks, the growth may be arrested and even made to disappear. It is a mistake, however, to radiate these patients late when the growth is large as the toxic absorption occasioned only hastens the end.

Abel of London feels that the only sensible step is radical removal of the esophagus. He feels that from 30 to 50 per cent of these cases are operable when first seen by the surgeon. As I have previously stated metastasis to adjacent tissues and lymph nodes is of late development so that seen in the early stages of this almost always fatal disease, the radical operation promises much. With our great strides in the art of surgery I hope the time will come when we can offer more to these unfortunates.

CONCLUSION

In patients over thirty, especially if it be a male previously free from digestive disturbance, complaining of the slightest difficulty in swallowing the possibility of cancer of the esophagus must be considered and further investigation by the *X*-ray and esophagoscope undertaken. Our greatest hope is early diagnosis.

(2) If the growth is small and accessible, radium may be used, but better results will be obtained by deep *X*-ray therapy. With perfection in technique the radical removal of the esophagus will have a much greater place in treatment.

(3) If the growth is large, dilatation and proper feeding will often prolong life in comfort many months.

DISCUSSION

WM. L. DEETON, M.D., Cleveland: I wish first to thank Dr. Dixon for the excellent and stimulating presentation of his subject—"Cancer of the Esophagus", which has been so well covered that there is very little left for one to add. However, it stimulated me to review the cases of cancer of the esophagus that we have had at the Cleveland Clinic since 1921. The series consists of 142 cases, and it is remarkable to see how closely our figures compare with those of Dr. Dixon. In our series, the male predominated three to one. The ages varied from 38 to 83. The greatest number of patients were between the ages of 51 and 60.

Age *	*Number*	*Per cent*
31—40	4	2.8
41—50	30	21.4
51—60	47	33.5
61—70	39	27.8
71—80	20	14.2
	140	

* In two patients the age was not recorded.

In Dr. Dixon's series, one-half had carious teeth. In 98 of our cases the condition of the teeth was mentioned on the chart and of these,

60 had neglected teeth and 26 others wore plates, showing that they had previously had bad teeth. Only 12 of 98 had good teeth. (I might say here that the data on our early charts were not nearly as full as that which we now record in our histories. That is why there were no dental reports in 44 cases). The question of tobacco as a causative factor in cancer of the esophagus and stomach has often been raised inasmuch that men are heavier users of tobacco than women.

Out of 82 patients, 51 or 62 per cent used tobacco.

Alcohol was used by one-third of 83 patients, which figure is identical with that of Dr. Dixon's. From observation at least one-third of normals use alcohol.

In 95 patients the Wassermann and Kahn tests were positive in only five cases.

Of 81 patients, the blood sugar was above normal in 17, or approximately one-fourth of the cases.

Of the total number of cases (142) 63 were Anglo Saxons and 79 were of Jewish or Southern European descent.

Our figures also support Dr. Dixon in his belief that heredity is a very doubtful factor. From 92 patients whose family history was recorded, only 18 or approximately one-fifth had a family history of carcinoma.

In studying the past illnesses of these patients it was quite striking to see that most of the patients had usually been very healthy during their life time. Occasionally, a patient would admit to a pleurisy or a pneumonia, but the great majority had always enjoyed good health. It was surprising to me to see that of 128 cases 20 had had typhoid fever. However, since there are no lymphatic patches in the esophagus this probably is of little significance.

In our series we found, as did Dr. Dixon, that in males the most common location of carcinoma was at the middle and lower third, and in women in the upper third.

In 137 cases the lesion was localized by means of *X*-ray, and in 67 patients an esophagoscopy was done.

Lower third	67	(M-56
		(F -11
Middle third	42	(M-33
		(F - 9
Upper third	25	(M-10
		(F -15

In 67 cases the lesion was found to be at the cardiac end of the esophagus. Only 11 females had the lesion here as against 56 males. In 42 cases the lesion was found to be at the middle third of the esophagus, and here again only nine of 42 cases occurred in females. However, of the 25 cases situated at the upper end of the esophagus, 15 occurred in women and only 10 in men.

As Dr. Dixon mentions, the symptoms of cancer of the esophagus are slow to appear. I most certainly agree with him that difficulty in swallowing is the first symptom to appear in by far the greatest number of cases. I would say that in our series also the patient usually waited about five months before consulting his physician. However, the time varied from two weeks in some to a year in others. In 111 of 137 cases the first symptom was difficulty in swallowing. In the total 142 cases, 137 had difficulty in swallowing as one of the symptoms. Epigastric pain was the first symptom in 11 cases and dysphagia was the first symptom in only six cases. Vomiting was present in four. This was a common complaint in foreigners who spoke poor English. When you pin these people down however, they admit they regurgitate the food they attempt to swallow. Loss of weight brought in two patients, indigestion two, hoarseness two, heart burn and throat trouble one each.

Along with difficulty in swallowing, hoarseness was present in 14 out of 137 cases. Hemoptysis occurred in 13 of 139 cases, and dyspnoea in 27 of 136 cases. Cough occurred in 33 of 139 cases. At the time of examination 50 of 138 cases had some dysphagia. Many others, however, later developed it. Another striking point in our series was the noticeable amount of weight loss in a short period of time. Ten pounds and over was the loss in 104 patients, and 55 patients had lost from 25 to 77 pounds in weight.

A biopsy was done on 23 patients of 138. Of these, 12 were squamous celled and three adenocarcinomas.

Of the larynges examined in 54 patients there was a left abductor paralysis in six cases, a right paralysis in one case, and a bilateral abductor paralysis in one case. In only 13 cases was there any enlargement of any glands in the neck. Four cases had palpable metastasis to the liver. Two cases showed definite metastasis in the chest, and one had a metastasis in the humerus.

Advice given these patients varied from conservatism with symptomatic treatment, dilatations, radium, *X*-rays, gastrostomy and various combinations of radium, *X*-rays and gastrostomy or jejunostomy. The use of *X*-rays and radium in our hands has been disappointing. Sometimes it seemed to prolong life but in others it seemed to only hasten the mediastinitis of which most of these patients die. Gastrostomy was done on 29 of 121 reported cases.

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—OSMJ—

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MANAGEMENT OF STRABISMUS

By ROBERT F. THAW, M.D., Akron, Ohio

IN THE treatment of strabismus the objectives to be attained are straight eyes, binocular vision with the development of a fusion faculty and a convergence near point of from 13 to 18 inches; these objectives to be attained in as short a period as possible after the appearance of the strabismus.

The reason for stressing the importance of early correction in these cases is due to the fact that amblyopia, one of the great barriers to success in the correction of strabismus, develops very rapidly after one eye becomes crossed. The greatest loss of vision occurring in the first eighteen months after the appearance of the strabismus.

There also is the psychological aspect to be considered, and in my opinion this is of as great importance as the prevention of amblyopia.

Psychologists are agreed that the period from three to twelve years in the life of a child is of greatest importance as far as character formation is concerned. A disfiguring deformity, such as a crossed eye, is a continual source of embarrassment and does not excite sympathy in its playmates but rather ridicule and bestowing of obnoxious nicknames. This in turn results in the development of an inferiority complex and other faults in character development.

Then in considering the management and treatment, bearing in mind these two great handicaps that rapidly become worse; one functional the other psychological, we should be determined that these patients will be corrected of their strabismus within nine months to a year after coming under our care.

First, of course, is the correction of the error of refraction. In the meantime cover the uncrossed eye about six hours a day to stimulate the macular area in the crossed eye. The patient should also have orthoptic exercises once a week from thirty minutes to an hour's duration.

If the correction of the error of refraction, covering the uncrossed eye and orthoptic exercises, are going to be a success the eye will be straight in six to nine months. If they are not in that length of time, there is no reason to continue this procedure over months or years longer.

It is now time to explain to the parents of these children that they should be operated and to disregard the advice that is so frequently given to delay operation until the child is fourteen to sixteen years of age, as they will by that time have passed through the important development period of their childhood and will have an established amblyopia which by this time will only be slightly improved if at all, by straightening the crossed eye.

By suggesting an operation you are recommending a procedure that, with a well developed technique, will be a complete success in practically all cases, one in which there is a very remote danger of infection that will cause the loss of an eye, and that it can be done at so early an age that the child will never be conscious of having had such a deformity as a crossed eye.

The problems presented in operating children are that the eyes become perfectly straight when the child is completely anaesthetized and as exact measurements do not give exact results we have no method of determining the exact amount of correction to make. So it is a decided advantage if we are to correct the majority of these at one operation, to be able to do it in two stages. One while the child is completely anaesthetized and also be in a position to do further correcting after recovery from the anaesthetic.

The supposition will be that you have had the patient you are contemplating operating under your observation for several weeks or months and have found that the eyes are not straight from your previous treatment. You have tested the vision in the crossed eye. If it is below 20/50 there will not be required as much over-correction as if it were better than 20/50. If external rotation is normal as much over-correction will not be required as if it is restricted to the median line or only slightly beyond.

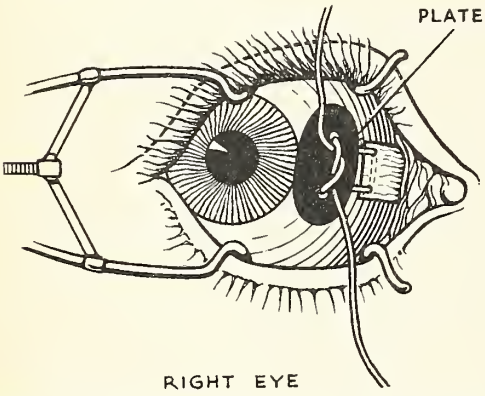
In operating on these cases of strabismus for a number of years, I have used a technique which I have found very satisfactory. In describing the operation I am going on the assumption that this is a monocular convergent strabismus, although it is applicable to any of the ocular muscles.

The internal rectus muscle is dissected free from the surrounding tissues, keeping well above the body of the muscle as they are very rich in blood supply and any nicking of the muscle will cause a free flow of blood interfering with the operation. If this is done the dissecting free of the muscle is practically bloodless. After the muscle is dissected free it is grasped with advancement forceps and is severed, being sure no muscle fibers remain unsevered. There is then passed through the muscle from below upward, a double armed waxed linen suture, this about three m.m. from the severed end of the muscle. Each one of the needles is then passed through the stump of the muscle at the superior and inferior borders, then passed through two holes in a hard rubber disc. One tie is then taken in the suture.

Read before the Eye, Ear, Nose and Throat Section, Ohio State Medical Association, at the 88th Annual Meeting, Columbus, October 4-6, 1934.

The function of this disc is to prevent the suture from pulling out when tension is placed on it, as shown in accompanying illustration.

The external rectus is now dissected free and grasped with advancement forceps and is severed leaving about three m.m. of the stump. A double armed O plain cat gut is now passed completely through the stump. The severed end of the muscle is pulled forward and the eye back to the point on the muscle where you desire the attachment, being sure that you have an over-correction. Both needles are passed through the muscle taking considerable of the body of it. It is then tied with a square knot. Then a single armed suture is passed through the superior border of the muscle and through the superior border of the



stump, and one through the inferior border of the muscle and the inferior border of the stump, the object being to fan out the muscles giving as wide an attachment as possible. The excess muscle is then severed within about two m.m. of the suture. The eyes are now bandaged and the child is returned to its room.

The next morning the child will have recovered from the anaesthetic. The bandages are removed, and the child is told to sit up in bed and focus on some object such as a light or a toy. You should find then that the eyes are over-corrected or about in the position that you desired.

The child is placed on its back. A nurse holds its head, another the lids apart and the linen suture to the internal rectus is tightened pulling the internal rectus forward until the eye is straight Then a second tie is taken in the suture to hold the muscle in position.

If the eye is not over-corrected and is in about the position desired there should be some tension placed on the muscle by tightening the linen suture so the internal rectus will attach beyond the equator of the eyeball that you have a functioning internal rectus.

The ocular muscles will become attached to the eyeball in any position in which they can be held in intimate contact and are remarkable for the rapidity with which they attach themselves to the sclera. It is not necessary to suture them directly to the sclera but they can be held in position by the linen suture through the stump.

Advantages of this operation are: no sutures taken in the sclera, all of the suturing being done in the stumps of the muscles, lessening the danger of severe infection in the eyeball.

One is able to do some correcting after the child has recovered from the anaesthetic and the eyes are coordinating normally.

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DISCUSSION

A. L. BROWN, M.D., Cincinnati: As Dr. Thaw states, the early correction of strabismus should be attempted primarily for saving or correction of the amblyopic eye. If the child is under three, orthoptic training is of no avail in my experience. The child can not be really made to cooperate thoroughly enough to be sure he is using both eyes together. If exercises of the crossed eye are of no avail within six to nine months as the author states, I am not only in accord with the author's statement, but wish to emphasize the importance of reducing the acute angle of the visual axes by operation. At this point all the doctor's persuasion and explanation to the parents is necessary and often to the attending pediatrician. I have never seen a case recover with glasses and training alone after having been crossed more than 15° for a year without improvement.

My own experience with the newer developments of operative technic is that the child under general anesthesia can be straightened in one operation by very definite measurements. Jameson has led us to a more accurate method of muscle placement than anyone in the last 25 years. My procedures follow his rather closely, including his measurements which have been found to be quite accurate for practical purposes. In the case of internal strabismus, a recession of the internus is done first, using triple 'O' chromic cat gut which is left buried. In the main, one millimeter of recession will give 5° of correction provided the body of the internus is strong and also the body of the externus has considerable tonus and is in no way paretic. If the deviation is more than 20° a combined resection of the externus is necessary. In this case, practically 2 m. m. is equal to 5° of correction and must likewise be considered after inspection of the muscle. Most of the failures are not due to errors of computation but of execution. In both recession and resection the needle must be entered 1½ m.m. behind the computed point, for fully that is necessary for a good hold of the needle in the tissues. Since both muscles in many cases are replaced, both eyes should be bandaged for four days to allow the new attachments to become firm. A stay suture as described by Dr. Thaw in my experience has not been a regulatory one, because the tissues begin to unite at once, and if drawn upon, the muscle will simply buckle without actually being moved. The cat gut sutures have the great feature of being absorbed, which is a great advantage in young children.

As Dr. Thaw intimates, this question can not be emphasized too much, because our duty is not only to learn proper methods of caring for strabismus cases, but to educate the parents and the family doctor early as to the newer point of view which does not allow neglect of such cases.

GLYCOSURIA IN PREGNANCY AND ITS CLINICAL SIGNIFICANCE

By HENRY J. JOHN, M.D., Cleveland, Ohio

GLYCOSURIA

IT IS rather common to find glycosuria in a pregnant woman. Hence it is customary for obstetricians to examine the urine of pregnant women for sugar at regular intervals. In the literature there is an enormous number of such reports, and in order to abbreviate, I am tabulating these results in Table 1. Glycosuria in

TABLE 1

GLYCOSURIA FOUND DURING PREGNANCY IN ROUTINE EXAMINATION

	Year	No. cases	Per cent glycosuria
Crock (7)	1925	548	30
Blot (2)	1856		50
Williams (59)	1925	500	13.6
Smit (49)	1927		10
Reichenstein (40)	1925		12
Lepine (29)	1909		40
Stopler (51)		32	18
Mann (31)	1913	30	3.3
Williams (58)	1907	3000	0.8
Faught (12)	1926	100	4.3
Rowe et al. (43)	1931	100	18
Labbe and Chevki (26)	1926	53	6
Wolff (63)			33

pregnancy might be explained on the basis of an increased permeability of the kidney for sugar (lowered renal threshold) as advocated by various authors: Novak, Porges and Strisower,[35] Frank and Nothmann,[13] Guggisberg,[16] Elias, Güdemann and Roubitschek,[11] Labbé and Chevki,[26] Elias,[10] Rabinowitch,[39] Williams and Wills,[62] Maase,[30] Heynemann,[20] and Nakayama.[32]

CHANGES IN THE PANCREAS DURING PREGNANCY

In some cases of pregnancy the accompanying hyperglycemia and its resultant glycosuria might be explained on the basis of alteration in the insulogenic apparatus, if such changes could be demonstrated; Nevinny and Schretter[34] have summarized this from accessible literature. Such reports are comparatively rare. Seitz[45] demonstrated them originally and Rosenlöcher[42] confirmed his observations of morphologic changes in the islands. Rosenlöcher found that the groups of intertubular cells were diminished in number and appeared to be swollen. The number of the islands also was diminished. The individual cells increased in size, they were polymorphic, showing but faintly. Sirtori[48] found a shrinking (increase?) of the islands. Poll[38] also found a change in the island cells of animals which he spoke of as morphologically diminished in function. Such morphologic changes could well go on to an irreparable damage of the islands of Langerhans.

We have no knowledge of just how this damage to the islands comes about. Some authors hold that sympathotony during pregnancy is a factor which inhibits the function of the islands. Others think that the changes in the various endocrine glands might furnish an explanation.

Nevinny and Schretter[34] summarized the above considerations as follows: "In spite of the different opinions and contradictions, when we consider the influence of the endocrine factors during pregnancy influencing the carbohydrate metabolism in connection with the pancreatic activity we have to come to the conclusion that the inner secretory constellations observed by all authors as affecting the pregnancy and in turn they play an important role in their influence on diabetes and also can produce diabetes during pregnancy."

A case reported by Umber and Rosenburg[52] illustrates an interesting point. A woman who during her second pregnancy showed glycosuria and hyperglycemia, continued to show this for five years, when, after her third pregnancy, her urine became completely sugar-free. The curve, however, is higher, though prediabetic in type and I am inclined to believe that the aglycosuria of the patient is due not to an improved condition but to a higher renal threshold.

RENAL THRESHOLD FOR SUGAR IN PREGNANCY

There is no absolute rule or figure for normal renal threshold. Observation must be based on large groups of cases with various affections and the average renal threshold must be estimated for each group. Within each group there will be extreme variations, and it is for this reason that it is impossible to apply any definite rule to the individual case. Some time ago I analyzed a large series of cases with various affections, estimating the average renal threshold in each group; (John[24]). Just a few of these groups are given in Table 2. From this table you will note the varia-

TABLE 2

RENAL THRESHOLD IN VARIOUS AFFECTIONS
(John)

Disease	Average renal threshold
Diabetes	212
Hyperthyroidism	147
Obesity	170
Tuberculosis	156
Hypotituitarism	162
Acromegaly	174
Hypertension	165

tion of the "average" threshold of these various groups. Now, if these are compared with the average renal threshold for the group of pregnant women in a subsequent table it is found that a high renal threshold is an exception in the latter series.

Hence it is clear that the renal threshold in

pregnancy is lower than in most other conditions. However, a series of twenty-five cases is far too small to permit final conclusions. The renal threshold in this group was estimated from glucose tolerance tests and is therefore quite accurate. In nineteen cases or 76 per cent the renal threshold was below 150, and in only six or 24 per cent was it above 150. The average threshold for this group was 123 milligrams per hundred cubic centimeters which certainly is low.

Glycemia. Williams and Wills[62] asserted that the blood sugar curves of normal, nonglycosuric pregnant women in all periods of pregnancy and during the puerperium fell well within the normal range of curves obtained from normal, nonpregnant women. The blood sugar curves in normal, nonglycosuric pregnant women tended to drop and to return to normal within a few weeks. The renal threshold, according to these authors would appear to be lowered in the majority of normal pregnant women, probably in all, although this point could not be shown conclusively. In my series which I am reporting here, the renal threshold was low. (Table 3).

TABLE 3

RENAL THRESHOLD IN PREGNANCY
Estimated from the glucose tolerance test. (John)

Renal threshold Blood sugar mg. per 100 c. c.	No. cases	Per cent
60-70	2	
70-80	2	
80-90	2	
90-100	1	
100-120	6	
120-130	2	
130-140	3	
140-150	1	
	19	76
150-160	2	
170-180	3	
200-210	1	
	6	24
Average renal threshold, 123 mg. per 100 c. c.		

Höst[23] in his study of the glycosuria of pregnancy and the blood sugar level found in the early months of pregnancy that the renal threshold was normal and the increase in blood sugar was often remarkable, so he felt that the glycosuria was due to the marked hyperglycemia and was not of renal origin. During the later months of pregnancy, on the other hand, the level of blood sugar rose but slightly. The renal threshold, however, was often so low that glycosuria frequently occurred, and, in this stage of pregnancy, might rightly be termed renal.

According to Rowe et al,[43] the blood sugar level during the course of normal pregnancy tends to assume low normal or slightly subnormal values, (90 to 110 milligrams per hundred cubic centimeters). Beginning two weeks after delivery, there is a consistent rise which assumes wholly normal levels. There is every evidence, he says, that ante-partum glycosuria is in no way produced by hyperglycemia.

Hellmuth[19] stated that the blood sugar is normal during pregnancy and frequently becomes lower during the last two months. During labor he found a considerable rise. He said that the blood sugar in the newborn is always lower than in the mother, which statement also has been made by Révész and Turolt.[41]

THE FREQUENCY OF PREGNANCY IN DIABETIC WOMEN BEFORE THE INSULIN ERA

Before the introduction of insulin, diabetic women were sterile. Table 4 includes data gathered from the literature, which show the small incidence of conception. While there is no way of knowing in what type of case conception took place, I should venture to say that it was in the very mild cases of diabetes.

TABLE 4

FREQUENCY OF PREGNANCY IN DIABETIC WOMEN BEFORE THE INSULIN ERA

Author	No. of diabetics	Per cent of pregnancies	Remarks
Naunyn (33)			One case only
Bouchardat (3)			None
Offergeld (36)			64 cases up to 1908 reported from the literature
Seitz (46)		5	
von Noorden (54)	240	3.7	
Umber and Rosenberg (52)	300	7	
Lecorche (28)	114	6.1	
Wiener (56)	20	5	
von Frerichs (53)	104	6	
Schützeberg (45)	589	5	
Lambie (27)		5	
Duncan (9)			22 cases from the literature (1881)
Williams (61)	66		
Parsons, et. al. (37)	285	3.8	Since 1922

Now since the advent of insulin, women who have been sterile, women who have not menstruated for years, return to a normal status, have regular periods and bear healthy children with a reasonable degree of safety.

MORTALITY OF DIABETIC MOTHERS IN THE PREINSULIN ERA

The mortality of diabetic mothers in the preinsulin era was quite high according to data given by various authors, presented in Table 5. In

TABLE 5

MORTALITY OF DIABETIC MOTHERS IN THE PREINSULIN ERA

Author	Year	Per cent mortality	
Hirschfeld (21)		50	
Williams (57)	1926	27	23% additional died in two years
Hansen (17)	1928	17	
Colorni (6)		46	in the first two years
Wiener (56)	1923	30	21% additional in two and one-half years postpartum

addition to the immediate mortality at parturition there was an additional mortality (21 to 46 per cent) within the next two years after parturition, which undoubtedly was due to the diabetes itself and not to pregnancy. In the past the whole picture was rather sad just as were pictures of diabetic coma before insulin. Now there is an infinitely more cheerful outlook.

HEREDITY OF DIABETES IN CHILDREN BORN OF DIABETIC MOTHERS

The heredity of diabetes in children born of diabetic mothers was reported by Weichselbaum[55] to be 25 per cent. The literature is sadly lacking in information on this subject.

Latent diabetes brought to the foreground during pregnancy was reported by Umber and Rosenberg[52] in six instances.

FETAL MORTALITY IN CHILDREN BORN OF DIABETIC MOTHERS TREATED WITH INSULIN

Hansen[17] gathered from the literature, twenty-six cases of children born of diabetic mothers with a mortality of 43 per cent. Wolff[63] stated that 10 per cent of all babies born of diabetic mothers die during the first year of their life. The incidence of mortality as given by numerous other writers is equally high.

One must bear in mind that glucose (an abnormally high blood sugar) is an excellent stimulant to the insulogenic apparatus. It may well be that the high fetal mortality is due to hyperinsulinism for the high blood sugar could bring about an over-abundant insulogenic apparatus in the fetus, which, as long as it has to deal with maternal hyperglycemia, adjusts itself to that level and function, in this compensatory manner accordingly. But, once the fetus is born, it has no longer the stimulation of hyperglycemia but depends on its own stores and supplies and such an hypertrophic organ with its increased function becomes a boomerang. There is too much insulin now for the bodily needs, a hypoglycemia results and the infant dies in the hypoglycemic stage without this being recognized. How many obstetricians do a blood sugar on an infant? Gray and Feemster[15] reported such a case of compensatory hypertrophy of the pancreas with the death of the baby from hypoglycemia. Here is a problem which certainly needs a great deal of work in order to elucidate and to settle it. Furthermore, one should try to control the hyperglycemia in a pregnant woman in order to obviate this. Thus far this is a theoretical consideration until such a time as we know the true state of affairs. But one must also try to avoid hypoglycemia in the mother which might be equally disastrous to the fetus.

Big babies. The fact that babies born of diabetic mothers are larger than those of nondiabetic mothers has been noted by many authors. An axiom has developed among the obstetricians "a big baby, rule out diabetes in the mother". While there are many data in the literature calling attention to large babies born of diabetic mothers (see Table 6) yet statistical evidence of this relationship in any large series is lacking. These sporadic instances of large babies gathered from all over the world are the "unusual" things that happen and one is likely to report the unusual incidence and not the common every day event. Is the incidence of large babies born of diabetic mothers actually greater than that of large babies born of nondiabetic mothers? For this answer we have to look to those who practice the art of obstetrics; give us figures of all babies born of diabetic mothers so that we may see how frequently the megalofetus occurs. Judging from the data available it would appear that the fetus born of a diabetic mother is much larger than the one born of a nondiabetic mother. Williams[60] gave as the average weight of a newborn, 7.25 pounds. The average weight of babies born of diabetic mothers as gathered from Table 6 was 10.1 pounds. Colorni[6] stated that 19.5 per cent of babies born of diabetic mothers are large (over 5000 gm. or 11 pounds) and Offergeld[36] gives such an incidence of 20 per cent.

TABLE 6

WEIGHT OF BABIES BORN OF DIABETIC MOTHERS

Author	Pounds 5	6	7	8	9	10	11	12	13	14	15	16
Barncock & McCard (1)								3				1
Bowen (4)		1	1		1	1	1					
Bowen (5)	1	1	1		1	2	1					
Colorni (6)					1	1	1				1	
Dubreuil & Anderodias (8)							1					
Frühinsholz (14)	1						2					
Hanssen (18)					1							
Holzbach (22)						10						
John (pre. publ.)			1	2	1		1	2				
Nevinny and Schretter (34)							2		2	1		1
Schretter and Nevinny (44)			2				2					
Springer (50)							2					

SOME PRACTICAL CONSIDERATIONS IN THE TREATMENT OF DIABETES IN PREGNANCY

Joslin[25] pointed out the seriousness of pregnancy in connection with diabetes. Priscilla White who wrote the chapter in Joslin's book stated that of 89 pregnancies in their series of diabetics, 25 were diabetic before the pregnancy and 33 became diabetic during the pregnancy (56.8 per cent). Springer[50] told of a patient showing only a slight glycosuria at term, yet that same woman died a few months later in true diabetic coma. White says that just because patients show subsidence of symptoms after confinement, does not mean that they are well and she cites one case that was followed for some weeks after confinement. The urine and the blood sugar were always normal, yet three months after confinement, diabetes appeared. Against this stands out another case showing 9 per cent sugar during pregnancy which disappeared for eight months after delivery. Ten months later, that same patient was readmitted

to the hospital with heavy glycosuria, acetonuria and a blood sugar of 300.

There are certain practical points in connection with pregnancy which one must bear in mind in spite of the contradictory statements in the literature as to the cause of this. The point which is of practical importance to the obstetrician as well as to the patient is: Is this glycosuria due to diabetes or is it merely a nondiabetic glycosuria? I can best illustrate this by telling you of two such instances which I think illustrate classically the problem in question.

Case 1. The patient was a young married woman 24 years of age, who consulted me because of the presence of sugar in the urine. There was no familial history of diabetes. During childhood the patient had had measles, diphtheria and scarlet fever. She had been married six years and had two children, the youngest being five months old. During her last pregnancy her obstetrician had found sugar in the urine about a month before parturition, but the patient was told that it was likely milk sugar and no further attention was paid to the circumstance.

During the six months since parturition the patient had had no special symptoms until a week before she consulted me when she had begun to have excessive thirst and frequency of urination. She consulted her family physician who found a marked glycosuria and prescribed a diet which she had followed for three days just before I saw her. At this time, her fasting blood sugar was 107 mg. per hundred cubic centimeters of blood. There was a slight trace of acetone and the sugar content of the urine was one-plus. Although her blood sugar was normal when I first saw her, in view of the fact that the patient had had glycosuria just before parturition and had so recently shown definite clinical signs of diabetes, I advised a glucose tolerance test which was performed on the following day. The characteristic blood sugar curve of diabetes was obtained as is shown in Chart 1. (Case 1.)

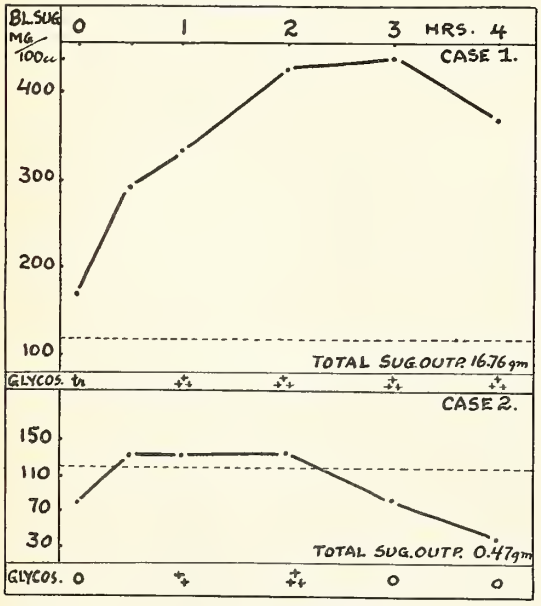


Chart 1. Chart showing blood sugar curve for cases 1 and 2.

It will be noted that the fasting blood sugar on this date was 167 mg. per hundred cubic centimeters of blood, whereas the day before it was only 107 mg. per hundred cubic centimeters of blood. The morning urine on the day of the glucose tolerance test showed only a trace of sugar, whereas on the preceding day, although the blood sugar content was lower, the urine sugar was one-plus. During the glucose tolerance test, the patient took in 100 grams of glucose and excreted in the urine 16.76 grams. The blood sugar curve goes high and shows a definite diabetic status.

Case 2. This patient was a young married woman, 24 years of age, who was in the third month of her first pregnancy. There was no familial history of diabetes. During childhood she had had measles, mumps, chickenpox, diphtheria and whooping cough; and later in life tonsillitis, grippe and pleurisy. Ten years previously a tonsillectomy had been performed and an appendectomy had been done seven years before.

The patient had been referred to me by her obstetrician who two weeks before had found sugar in the urine. The frequency of urination had been increasing, so that when I first saw her she had to get up every two hours during the night. When I examined her the fasting blood sugar was 73 mg. per hundred cubic centimeters of blood, and there was no glycosuria. Three days later I made a glucose tolerance test, the results of which are illustrated in the Chart 1. (Case 2). This normal curve shows that this patient had a low renal threshold for sugar, for although the highest blood sugar level was 138 mg. per hundred cubic centimeters of blood, glycosuria was present at the end of the second hour. The total output of sugar was but 0.47 grams, in marked contrast to the output of the first patient.

The two cases here described show the two contrasting findings in patients who have glycosuria during pregnancy. They show that the glycosuria in itself is but a symptom and is not of final diagnostic significance, but that it calls for further investigation. The first patient required treatment for diabetes, while the second patient did not. On the one hand, to disregard the presence of sugar in the urine in such cases might mean that the patient would be deprived of a vitally needed protection; and on the other, to subject every such patient to the routine treatment for diabetes might mean a dietary restriction and a psychic strain which the patient could and should be spared.

The glucose tolerance test, after all, offers us information which is specific and helps us to differentiate the diabetic from the nondiabetic. I did thirty-three such tests on thirty-three women showing glycosuria during pregnancy or during the early part of puerperium. One hundred grams of glucose were used and the estimation was done by the Myer modification of the Baily method.

The data obtained from these glucose tolerance examinations in the thirty-three cases of glycosuria in pregnancy give the following information: (Table 7.)

TABLE 7
GLUCOSE TOLERANCE TEST IN PREGNANCY
(John)

	No. Cases	Per cent	
Total cases	33	100	
Normal curve in	18	54.5	
Prediabetic curve in	6	18.1)	45.5
Diabetic curve in	9	27.4)	
Renal threshold from 60 to 150 in	19	76	
Renal threshold from 150 to 210 in	6	24	
Renal threshold—average—123.			

In this series, about half the patients proved to be diabetic. The series is too small to draw any conclusions regarding percentage incidence but it also shows the heavy incidence of abnormal carbohydrate metabolism.

The renal threshold, as can be seen from Table 3, is quite low, being below 150 in 76 per cent and above 150 in 24 per cent. The average renal threshold was 123, which is low.

In going over a similar series of glucose tolerance tests reported by Selman[47] in this section last year, and rearranging his data according to my standards, I find the following: In a total of forty-nine cases, 72.2 per cent gave a normal curve and 27.5 per cent a diabetic curve.

In Table 8 can be seen the relationship of weight to the type of glucose tolerance curve.

TABLE 8
THE RELATIONSHIP OF WEIGHT TO THE GLUCOSE TOLERANCE TEST
(John)

		Glucose Tolerance Curve		
Weigbt	No. cases	Normal	Prediabetic	Diabetic
Normal	27	19	4	4
Plus 20-30%	2		1	1
Plus 50-60%	4		2	2
Normal weight—Diabetic incidence 29.6 per cent				
Obesity —Diabetic incidence 100 per cent				

The old principle, that obesity predisposes to diabetes, seems only too evident here. Note the low incidence (29.6 per cent) in those of normal weight against the high incidence (in this case 100 per cent) in the obese patients. While we do not know exactly what part obesity and what part pregnancy plays, yet the figures are quite suggestive and point toward obesity as an important factor.

GENERAL DISCUSSION

1. Pregnancy induces changes in structures in certain organs of internal secretion (thyroid, pituitary, chromaffin system); there is an increased activity of these sugar mobilizing centers which may affect the glycolytic function of the pancreas.

2. The size of the thyroid is likely to increase in diabetic women during pregnancy (75 to 80 per cent of cases). This is an expression of insufficiency of iodine which should be administered. During gestation an increased thyroid hormone supply is essential. An increased thyroid function can be interpreted as an established, physiologic phenomenon of pregnancy.

3. Patients with defective thyroids (cretinism, myxedema, cachexia strumipriva) are harmed by pregnancy.

4. Patients with hyperthyroidism, on the other hand, according to French writers and Kocher, almost as a rule, are temporarily benefited by pregnancy.

5. Pregnancy demands an increased supply of parathyroid hormone; an insufficiency of this causes tetany. The removal of parathyroids in animals causes glycosuria and a decreased assimilation of carbohydrates.

6. The hypophysis enlarges during pregnancy. Occasionally this leads to a lateral hemianopsia especially for the red and green, the result of pressure against the chiasma. The field becomes normal in ten days post partum. This physiologic hyperactivity of the pituitary gland leads to a decrease of carbohydrate metabolism.

7. The intra-uterine mortality in diabetic women is stated to be high.

8. Diabetes furnishes a fertile field for toxemia of pregnancy.

9. Some authors think that simple pregnancy does not bring about diabetes; that it is only toxemia which brings this about (Wiener 56).

10. Pernicious vomiting of pregnancy may culminate in severe acidosis.

11. Coma may follow the withdrawal of insulin.

12. Diabetic women during pregnancy require calcium and cod liver oil as do nondiabetic mothers.

13. If a low diet is used it is likely to produce a small baby in a well controlled diabetic mother.

14. Chloroform should not be used during parturition of a diabetic mother as it damages the liver which is a dangerous procedure in a diabetic.

15. The production of hypoglycemia (excessive dosage of insulin) may lead to death of the fetus and bring about abortion.

16. Hyperglycemia in the mother is the likely reason for hypertrophy of the islands of the fetus in an attempt to take care of the excessive sugar and this in turn may lead to hyperinsulinism and the death of the fetus after its birth.

17. Increased tolerance in the mother during the latter part of pregnancy is due either to the additional insulogenic function of the fetus or to the fact that the fetus uses a large portion of the increase in glucose in the maternal blood.

18. It seems that children born of diabetic mothers are large, a 100:71 ratio. However, more statistical data are necessary to establish this point definitely.

19. There are cases on record of babies born diabetic though this seems quite rare. The incidence of diabetes in the off-spring born of diabetic mothers is given by Weichselbaum[55] as 25 per cent.

20. The blood sugar level in normal, nonglyco-

suric pregnant women is within normal limits or slightly lowered.

21. The finding of glycosuria in a pregnant woman calls for further investigation. A heavy carbohydrate meal and check of the blood sugar, two and one-half hours after this meal, will tell whether or not the patient is diabetic. A better procedure still is a glucose tolerance test where this is feasible. The renal threshold in pregnancy is low (in my series 123 mg. per hundred cubic centimeters).

22. A latent diabetes can be brought to the foreground during pregnancy according to Umber and Rosenberg[52] who report six such cases. A prediabetic woman who becomes pregnant should therefore be watched closely during pregnancy and puerperium.

23. In a series of thirty-three glucose tolerance tests, which I did on pregnant women, the incidence of a diabetic curve was high, that is, 45.5 per cent. This, however, is but part of the story. In this same group, 27 cases were of normal weight and in this group the incidence of diabetes was 29.6 per cent. Six were overweight, (20 to 60 per cent) and in this group the incidence of diabetes was 100 per cent.

24. A pregnant woman may show only a slight glycosuria at term and die a few months later in true diabetic coma.[50]

25. The mortality of diabetic mothers in the pre-insulin era was high (17 to 50 per cent). Now with insulin and proper diet a proportionate decrease of mortality is to be expected.

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MEDICO-LEGAL ASPECTS OF SILICOSIS IN OHIO

By PAUL M. HOLMES, M.D., Toledo, Ohio

I AM assuming that silicosis is universally considered an authentic occupational disease. This can also be said of silicatosis and asbestosis. During recent years there has accumulated an enormous amount of information about silicosis which establishes beyond doubt that this lung disease is the direct result of inhalation of silica or certain of its compounds. No one that I know disputes this fact. Granting then, that this disease is of occupational origin, it naturally follows that some compensation is due the disabled worker so affected. At present in this country we find the questions of when and how much to compensate, for the most part unanswered.

In only ten states and the Federal Government is there coverage for any specifically named occupational disease, and in only five of them is silicosis included. The worker may in 42 states seek redress through the common courts of law against his employer, and five states have such legislation that any condition traceable to occupation is compensable.

The State of Ohio occupies the unmatched position of not only excluding silicosis from its list of 21 compensable occupational diseases but also from its courts of law. This is the only state in the Union where the worker with silicosis does not have the right of redress. Ohio courts, with a sustaining ruling by the State Supreme Court, have directed that no suits for other than the specified occupational diseases will be allowed. The manufacturer under our present laws has perfect protection, and the worker none. This state of affairs can not last forever because of its manifest injustice. All of us who have had any lengthy experience with thoracic infections have seen many instances of prolonged disability and death from silicosis which have been uncompensated. On the other hand we have observed cases of tuberculosis of questionable traumatic origin receive compensation for years.

There are certain well-known facts about this disease that make any monetary settlement extremely difficult.

1. *Who shall be paid?* In spite of the fact that diagnosis is, in the hands of the experts, relatively simple, there are for the great majority of clinicians and roentgenologists great difficulties in identification especially if examination is made very early, or very late when tuberculosis obscures the picture. Differences of opinion, even among the experts, would seem to indicate a complexity not apparent from reading their literature. It is nevertheless true that there are a number of physicians proficient in the diagnosis of this disease, and whose opinion should be final. Certainly if I were a manufacturer I would hesitate to pay off on a diagnosis unless I was certain about the qualifications of the diagnostician. The exact diagnosis often requires a prolonged period of observation with numerous serially taken X-ray films to determine the presence or absence of characteristic nodulation without which no diagnosis of silicosis should be made.

2. *When and how long shall they be paid?* After the diagnosis is made the amount of disability must be determined. Repeated instances of silicotics living and working out their normal life span are on record. Certainly if there is no disability there should be no compensation. Here again is a worker who says he is weak, has lost weight, coughs and is short of breath, even though the findings are minimal, disability would be difficult to disprove. The separation of the faker from the deserving is often impossible. The worker who has a diagnosis of silicosis is very apt to stop work immediately until his claim is settled even though no disability exists. This is especially true when he expects a huge reward by winning a suit against the company. If the amount per week through a compensation board is less than his wage such a result is less likely to occur. Termination of a real disability except by death rarely happens. Seventy-five per cent of silicotics develop tuberculosis, a combination which is almost invariably fatal.

3. *Who pays?* Due to the extremely slow development of this disease to the point of disability (sometimes 20 to 30 years) and to the shifting employment of the worker, it is almost impossible to determine which employer to hold responsible. This also applies to states with different codes. Ontario requires a three- to five-year exposure in the Province before the claim will be considered. This, most authorities consider too long, as it is undoubtedly true that silicosis may develop in a few months' time. Within the last two years I have seen two quickly fatal cases with only 12 months of intensive exposure. The alert manufacturer is not only settling this problem, but protecting his workmen by periodic X-ray examinations. This will indicate the disease in its very incipiency or if the worker leaves the employer without X-ray evidence of injury it will serve as a bit of very useful information should trouble develop later.

X-ray examination upon employment insures the employer against assuming responsibility for silicosis acquired in another plant. Realizing

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that I have mentioned only a few of the difficulties encountered in the settlement of silicosis claims, nevertheless I want to proceed to a consideration of methods of compensation for disability in this very tragic disease.

First, through the courts. If only worthy claims were presented this would not be an objectionable method; however, experience in two states, Missouri and Illinois, have shown that hundreds of spurious claims are filed which require an expensive defense even though no damage is allowed.

An attorney recently stated to me that out of 190 claims for silicosis filed against one of their clients, only eight were genuine. The *X*-rays of all of these cases were studied by experts of unquestionable qualifications before making the above assertion. This same attorney also stated that 40 claims were recently settled for a total of $10,200. Some as low as $50 per claim, to save carrying them into court.

True silicosis is not a common disease. I am convinced from a study of admissions to sanatoriums that its incidence is low even in industrial centers, hence there is really no reason for so many claims. The number of these cases is bound to decrease, because of protective measures being installed by thoroughly alarmed manufacturers.

The ambulance-chasing attorney and his cohort, the doctor, solicit these clients and are directly responsible for bringing distrust upon the legal and medical profession. A doctor recently testified that he could diagnose silicosis without an X-ray film. Such ridiculous assertions to a lesser degree are being made in a great many cases by physicians who are not qualified to give an authoritative opinion. Certainly a defense based upon evidence of neglect is not sufficient, nor can reasonable settlement be expected in a majority of these instances because claimants will be coached by attorneys to demand sums out of all proportion to their injuries.

Second, private insurance would be adequate, but here again through the filing of great numbers of claims of no merit would require a prohibitive premium which the small business man could ill afford. Insurance companies are not philanthropic institutions as the manufacturer would soon find out after a few claims for from ten to twenty thousand dollars had been settled.

These private companies are not taking risks where silicosis is involved. In some instances they do not want them no matter how high the premium.

This brings me to the third and last method, viz: the inclusion of silicosis in our list of compensable occupational diseases, and the establishment of a medical board of experts of unquestioned integrity to administer the act. At present this appears to me as the way I would like to have my state handle this problem. It seems that of all methods this would be most likely to bring a just and adequate settlement to the satisfaction of both employe and employer. If possible I should like this board of experts to have the final word in establishing the diagnosis, extent of disability and the amount of compensation.

The advantages would be:

1. More time could be taken to insure a correct diagnosis. Serial X-ray films, repeated sputum examinations, hospital observation.

2. More prompt consideration of claims, thereby preventing long time losses for the misguided worker, and quicker financial relief for the genuinely disabled. Court trials are frequently delayed 12 to 18 months during which time the worker is without income.

3. A better distribution of cost. Instead of a few bearing the heavy expense, it could be distributed over the whole industry with little or no financial sacrifice to the individual plant.

4. Prevention of exploitation of the worker, through the contingent fee, and the manufacturer by extortionate judgment.

5. Some reasonable and fair mode of eliminating as far as possible the aggravation or exciting a pre-existing condition clause thereby removing an insufferable load from the back of the manufacturer. If this is not done he is bound in time to be swamped especially in dealing with claims of this type.

6. It would place the whole subject upon a higher ethical plane.

SUMMARY

1. Silicosis is an authentic occupational disease, not particularly difficult to diagnose.

2. Ohio should provide adequate means of compensating all diseases ascribed to occupation.

3. Compensation for silicosis should be adjudicated through a medical board of experts attached to the Industrial Commission and whose decisions are final.

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—OSMJ—

Northwest Health Meeting

One hundred and fifty physicians and nurses from 22 counties in northwestern Ohio met at the New Secor Hotel in Toledo August 22, in the quarterly session of the Northwestern Ohio Health Conference.

Principal speakers were Dr. C. D. Barrett, director of communicable diseases and rural hygiene, Michigan State Health Department; State Health Director, Dr. Walter H. Hartung, Columbus; and Dr. Warren P. S. Hall, superintendent of the Toledo Food and Sanitation Bureau. Dr. Charles R. Keyser, Van Wert, presided.

Inspection tours were made of the Toledo sewage disposal plant and the filtration plant.

RECURRENT ACUTE INTUSSUSCEPTION

Treatment with Barium Enemas and Massage under Fluoroscopic Control

By M. M. MILLER, M.D., and C. L. BEATTY, M.D., Akron, Ohio

THE treatment of acute intussusception by any method more conservative than surgery has received scant attention in this country. On the contrary, the urgency of prompt surgical intervention has long been stressed to the exclusion of consideration of other valuable though less universally applicable means of treatment.

The danger and futility of non-surgical methods in the presence of the severe congestion, edema and resultant strangulation incident to delayed diagnosis are rightly appreciated and cannot be overemphasized. However, the possibility of avoiding operation in certain selected, promptly diagnosed cases has not been sufficiently recognized. The desirability of an effective means of relieving intussusception without repeated resort to surgery is especially great in the case of those individuals with recurrent attacks.

While the possibility of reducing intussusception in selected cases by means of hydrostatic pressure has long been known, this method, though still employed, has largely fallen into disrepute as being inadequate and dangerous. The chief reason for this has perhaps been the lack of visualization of results and the consequent uncertainty as to its efficacy in any given case. If, however, the results obtained can be determined with certainty as they can be under the fluoroscope, the method is sometimes of great value in certain selected cases.

Retan[1] in 1927 described a technique for the relief of acute intussusception by means of barium enemas and massage under fluoroscopic visualization. He stated that success with this method depends upon early diagnosis and application of the procedure within twelve hours of the onset of the intussusception. Stephens[2] in 1928 reported a case of recurrent intussusception in a baby six months old, three months after the child had been operated on for a similar attack, in which he relieved the second attack by means of a barium enema and manipulation under the fluoroscope; and a second case similarly treated successfully in a child two years and three months old. A number of similar reports have subsequently appeared, chiefly in the French, German and Scandinavian literature.

Recurrent intussusception is relatively uncommon but not rare. Most of the cases reported have occurred at varying intervals following operation. Cohen[3] reported four cases of postoperative recurrence. In addition to his own cases Cohen collected seventeen cases from the literature in which a total of thirty-six operations were performed for the reduction of intussusception, making a total of twenty-one patients operated on forty-four times. It is in such cases that the non-surgical approach of Retan and Stephens, exemplified in the following case report may be of the greatest value.

CASE REPORT

First attack. S.M., a boy 20 months old, was first seen by one of us (M.M.M.) at 10:00 A.M. on January 16, 1934. The mother stated that the child had been perfectly well until 8:00 A.M. that morning, when he was suddenly seized with pain which she interpreted as abdominal cramps. He rolled over on his side, drew up his legs, doubled up and screamed with pain. These symptoms continued intermittently, each spasm of pain lasting a few minutes. With each attack the child would become pale and ashen and have a cold perspiration, after which he would be limp and prostrated. He was nauseated but had not vomited. There had been two normal bowel movements the day before and one normal stool just before the attack. There had as yet been no passage of blood or "current jelly" mucous. There were no other symptoms.

The only relevant point in the past history was the mother's description of a similar but less severe attack of abdominal cramps which occurred from 2:00 to 3:00 A.M., August 11, 1933, five months before the present illness. It is not known whether this was an attack of intussusception, for the mother stated that the attack was relieved by several large enemas and abdominal massage without calling a physician. (That spontaneous reduction of intussusception sometimes occurs there can be no doubt and it is quite possible that some cases of severe colic are really cases of slight intussusception which may undergo spontaneous reduction.)[4]

Examination showed a well developed, fairly well nourished baby. His skin was pale and cool, temperature normal. Further complete physical examination disclosed no abnormalities except in the abdomen, palpation of which disclosed a sausage shaped mass, round, boggy, freely moveable, approximately one inch in diameter by three and one half inches in length in the right upper quadrant in the region of the first portion of the transverse colon. On rectal examination a soft mass was encountered which suggested an intussusceptum but which on further palpation receded out of reach of the examining finger.

The diagnosis was intussusception of the ileum into the cecum and ascending colon and the first third to one-half of the transverse colon. The child was then examined by a surgeon, Dr. B. H. Hildreth, who concurred in the diagnosis.

A barium enema was given under the fluoroscope. When the column of barium reached the mid portion of the transverse colon it stopped abruptly at the point which could be palpated

and visualized as the end of the sausage shaped tumor mass. We attempted to inject more barium under increased pressure but it would flow no farther. We then attempted to massage the intussusceptum out of its intussuscipiens by milking the barium toward the cecum. Gradually the barium began to flow in around the intussusceptum so that two thin divergent lines of barium were visualized in the space between the invaginated portion and the surrounding colon, definitely outlining the intussusceptum and its surrounding intussuscipiens. With further milking the intussusceptum began to recede, the barium following, until the ileo-cecal valve was reached, when a small amount of barium was milked into the ileum, completely relieving the obstruction. As soon as the obstruction was relieved the baby became bright, his color returned and he had no further symptoms.

A coincidental finding under the fluoroscope was a round, opaque foreign body in the rectum which proved to be a small rubber tire off a toy automobile. This object was about one-half inch in diameter and three-sixteenths inch thick.

Second attack. The child was well until April 6, 1934, when about 6:00 A. M. there was a sudden onset of intermittent abdominal cramps and prostration. He acted exactly as he did in the previous attack and the father called one of us one hour after the onset, stating that his baby's "bowels were locked again." The child vomited once about two hours after the onset.

On examination an almost identical situation was found. The child was pale, limp and prostrated and was having intermittent abdominal cramps. The mother had given several enemas and the abdomen was relaxed. Palpation again disclosed a boggy, sausage shaped tumor mass of the upper portion of the ascending colon and beginning third of the transverse colon. Rectal examination was negative.

The diagnosis of acute intussusception was confirmed by barium enema and fluoroscopy and the obstruction was again successfully reduced by massaging the barium toward the cecum. Relief of the abdominal cramps was again immediate and complete.

SUMMARY

A case of recurrent acute intussusception is reported, in which a child had one attack at the age of 20 months and a second attack nearly three months later.

In both attacks the child presented the symptoms (sudden onset, intermittent abdominal cramps, prostration and collapse) and the characteristic finding (sausage shaped tumor mass) of intussusception. In neither attack had sufficient time elapsed for the passage of mucous and blood.

In both attacks the diagnosis of intussusception was confirmed by a barium fluoroscopic examination within three hours of the onset and the obstruction relieved by extra abdominal manipulation.

CONCLUSIONS

This case furnishes additional evidence that intussusception may sometimes be relieved by nonsurgical procedures provided the diagnosis is made sufficiently early.

The use of barium enemas and massage under the fluoroscope appears to be a valuable procedure which deserves a therapeutic trial in all very early cases of acute intussusception.

REFERENCES

1. Retan, G. M., Am. J. Dis. Child., May, '27, Vol. 33, pp. 765-770.
2. Stephens, V. R., Am. J. Dis. Child., Jan., '28, Vol. 35, pp. 61-64.
3. Cohen, M., Am. J. Dis. Child., April, '21, Vol. 21, p. 410.
4. Holt and Howland, Diseases of Infancy and Childhood, 8th Ed., p. 406. D. Appleton and Co.

363 S. ARLINGTON STREET.

—OSMJ—

New Books

Diseases of the Thyroid Gland, (Third Edition —entirely re-written) by Arthur E. Hertzler, M.D., Chief Surgeon, Halstead Hospital; Professor of Surgery, University of Kansas; with a chapter on "Hospital Management of Goiter Patients", by Victor E. Chesky, M.D., Chief Resident Surgeon, Halstead Hospital. The C. V. Mosby Co., 3523-25 Pine Boulevard, St. Louis, Mo., publishers; price $7.50.

A Treatise on Medical Jurisprudence, by Benton S. Oppenheimer, LL.B., LL.M., Professor of Law, College of Law, University of Cincinnati; Professor of Medical Jurisprudence, College of Medicine, University of Cincinnati. A practical handbook for physicians, lawyers and students, dealing with medical jurisprudence and the practice of medicine; relation between physician and patient; duties and obligations of physician to patient; malpractice; actions, evidence, hospitals, dying declarations and miscellaneous topics. Price, $4.00, William Wood & Co., Boston, Mass., publishers.

Sex Worship and Disease, by Mason Daugherty, M.D., Cleveland. A scientific treatise on sex worship and its influence on religion and symbolism, with special reference to diseases of the sexual organs. Price $3.50. Sold by the Chicago Medical Book Co., Congress and Honore Streets, Chicago, Illinois.

Human Pathology, by Howard T. Karsner, Professor of Pathology, Western Reserve University School of Medicine, Cleveland. This is the fourth edition of this widely-used textbook. It has been extensively revised. The material on the general pathology of tumors, with minor exceptions, has been completely re-written. Price, $10.00, J. B. Lippincott Company, Philadelphia, Pa., publishers.

Living Along With Heart Disease. By Louis Levin, M.D., Cardiologist to the St. Francis Hospital and New Jersey State Prison Hospital, Trenton, N. J., with a foreword by Thomas M. McMillan, M.D., Associate Professor of Cardiology, Graduate School of Medicine, University of Pennsylvania, etc. The MacMillan Company, New York, publishers. Price $1.50.

HIGH SPOTS OF THE PROGRAM AND ENTERTAINMENT FEATURES OF EIGHTY-NINTH ANNUAL MEETING, OHIO STATE MEDICAL ASSOCIATION, WEDNESDAY, THURSDAY AND FRIDAY, OCTOBER 2, 3 AND 4, NETHERLAND PLAZA, CINCINNATI, OHIO

TUESDAY, OCTOBER 1

Annual tournament, Ohio Medical Golfers' Association, Maketewah Country Club.

WEDNESDAY, OCTOBER 2

Medical and surgical clinics at Cincinnati hospitals, 8:00 A. M. to 12:30 P. M., by members of the Cincinnati Academy of Medicine.

Opening Session of Annual Meeting and first meeting of the House of Delegates, 1:00 P. M., Hall of Mirrors.

Second General Session, 3:00 P. M., Hall of Mirrors, Dr. James B. Herrick, Chicago, Guest Speaker.

Third General Session, 3:45 P. M., Hall of Mirrors, Dr. Frank H. Lahey, Boston, Guest Speaker.

Dinner in honor of visiting women physicians, given by Medical Women's Club of Cincinnati, 6:00 P. M.

Fourth General Session, 8:15 P. M., Hall of Mirrors, annual addresses of President and President-elect, Dr. John A. Caldwell, Cincinnati, and Dr. R. R. Hendershott, Tiffin; address by Dr. Morris Fishbein, Chicago, Editor of *The Journal of the American Medical Association*, Guest Speaker.

THURSDAY, OCTOBER 3

First Sessions of Scientific Sections, 9:00 A. M.

Luncheon for Past-Presidents, Ohio State Medical Association, 12 noon.

Fifth General Session, 1:30 P. M., Hall of Mirors, addresses by Dr. R. Wesley Scott, Cleveland, and Dr. Leslie L. Bigelow, Columbus.

Sixth General Session, 3:00 P. M., Hall of Mirrors, program by members of the faculty, College of Medicine, University of Cincinnati.

Seventh General Session, Annual Banquet, 7:00 P. M., Hall of Mirrors, address by Dr. Gordon J. Laing, University of Chicago, Guest Speaker, "Are Doctors Human?"

FRIDAY, OCTOBER 4

Eighth General Session, 9:00 A. M., Hall of Mirrors. Final Session of House of Delegates.

Ninth General Session, 11:00 A. M., Hall of Mirrors, Dr. Palmer Findley, Omaha, Guest Speaker.

Organization Luncheon, 12:00 Noon, Pavillon Caprice. Address by the Hon. A. D. Caddell, secretary, State Industrial Commission.

Second and final sessions of six Scientific Sections, 2:00 P. M.

* * * *

Registration Headquarters, Fourth Floor Foyer.

Scientific Exhibits, North Exhibit Hall.

Commercial Exhibits, South Exhibit Hall.

Admission to all sessions will be by badge only, obtainable at Registration Headquarters, upon presentation of 1935 membership card.

THIRTY-SIX DEMONSTRATIONS ARRANGED FOR SPLENDID SCIENTIFIC EXHIBIT AT CINCINNATI MEETING

ONE of the outstanding features of the Eighty-Ninth Annual Meeting of the State Association, Wednesday, Thursday and Friday, October 2, 3 and 4, Netherland Plaza, Cincinnati, will be the Scientific Exhibit.

Thirty-six exhibits and demonstrations have been scheduled by Dr. Symmes Oliver and his Cincinnati committee on scientific exhibits, the other members of which are Dr. Alfred Friedlander, Dr. Oscar Berghausen, Dr. Joseph Ganim, Dr. George Guest, Dr. Robert Kehoe, Dr. K. V. Kitsmiller and Dr. Cecil Striker.

The Scientific Exhibit will occupy the beautiful North Exhibit Hall of the Netherland Plaza, located on the fourth floor adjacent to the Hall of Mirrors.

The exhibit will be open during all sessions of the Annual Meeting.

Proof of the diversity of the splendid exhibits which will be shown and the unusual interest in this feature on the part of the membership will be found in the following program of exhibits and exhibitors:

1. The Skin Manifestations and Treatment of Syphilis—by C. L. Cummer, Cleveland.
2. Preventive Procedures in Infancy—by T. K. Selkirk and J. V. Greenebaum, Cincinnati.
3. Epidemiology of the Common Cold—by J. A. O'Doull, Western Reserve University, Cleveland.
4. Correlation of Roentgenology and Pathology of Thorax—by H. B. Davidson, Ohio State University, Columbus.
5. Closed Method for Encephalography—by H. D. Piercy, Cleveland.
6. Collapse Therapy in Pulmonary Tuberculosis—by Theodore L. Bliss, Akron.
7. Demonstration of Action of Dacryorrhetin (Motion Picture with Kodachrome Film)—by Shiro Tashiro, Cincinnati.
8. Sight Saving Classes (Cincinnati Public Schools)——by Heberle School, Cincinnati.
9. Oral School for the Deaf—Cincinnati.
10. Allergy Exhibit—by Cleveland Allergy Society, Cleveland.
11. Life Masks and Anatomic Models—by Samuel Iglauer, Cincinnati.
12. Burns—Pathology and Treatment—by D. J. Kindel, Cincinnati.
13. Medical Classics Illustrating the History of Medicine—by David A. Tucker, Cincinnati.
14. Peripheral Vascular Diseases (Paveax)—by Louis G. Herrmann, Cincinnati.
15. Peripheral Vascular Disease (Paveax) pathologic specimens)—by Hamilton County Tuberculosis Sanatorium, Cincinnati.
16. X-ray Examination of Uterus and Fallopian Tubes—by E. C. Steinharter, Cincinnati.
17. Pulmonary Tumors—by Samuel Brown, Cincinnati.
18. Urological Diseases—by E. O. Swartz and H. B. Freiberg, Cincinnati.
19. Evolution and Decline of Human Dentition—by Samuel Rabkin, Cincinnati.
20. Nephroptosis—by Parke G. Smith and Gordon McKim, Cincinnati.
21. Cardio-Vascular Studies in Pregnant Women—by J. E. Benjamin, Cincinnati.
22. Eye Pathology—by Holmes Hospital, Cincinnati.
23. Hare Lip and Cleft Palate—by Reed Shank, Cincinnati.
24. Carcinoma of Rectum and Colon—by Thos. E. Jones, Crile Clinic, Cleveland.
25. Tumors of the Kidney—by W. E. Lower, Crile Clinic, Cleveland.
26. Natural Color Program of Cincinnati Health Department—by Cincinnati Department of Health, Cincinnati.
27. Tuberculosis Program of Cincinnati Health Department—by Cincinnati Department of Health, Cincinnati.
28. Climatic and Weather Effects on Man—by C. A. Mills, Cincinnati.
29. Cancer of Breast, Uterus, Skin and Face—by American Society for Control of Cancer, New York.
30. Tumor Clinic of Cincinnati General Hospital—by William Millar, Cincinnati General Hospital, Cincinnati.
31. Chemistry and Histology of Atherosclerosis—by Pearl M. Zeek, Cincinnati General Hospital, Cincinnati.
32. The Kettering Laboratory: Studies on Lead— by Kettering Laboratory, Cincinnati.
33. Microphotography—by Carl Hiller, Cincinnati.
34. Anemias of Childhood—by George Guest, Cincinnati.
35. Research Institute, Children's Hospital—by Glenn Cullen, Cincinnati.
36. Fractures—by John A. Caldwell, Cincinnati.

— OSMJ —

The new Federal Social Security Program will be administered by a three-man board, consisting of John G. Winant, former governor of New Hampshire, and more recently Chief of the National Labor Relations Board of the N.I.R.A., chairman; Arthur J. Altmeyer, Wisconsin, Assistant Secretary of Labor; and Vincent M. Miles, Arkansas lawyer.

PARTIAL SCHEDULE OF HOSPITAL CLINICS TO BE PRESENTED WEDNESDAY MORNING, OCTOBER 2, AT ANNUAL MEETING

MEDICAL and surgical clinics by members of the Cincinnati Academy of Medicine will be presented at Cincinnati hospitals on the morning of Wednesday, October 2, as the opening feature of the official program for the 89th Annual Meeting of the Ohio State Medical Association, October 2, 3 and 4, at the Netherland Plaza, Cincinnati.

An excellent program of clinics is being arranged by a Committee on Clinics, composed of Dr. Dudley Palmer, chairman, Dr. Lloyd B. Johnston, associate chairman, Dr. J. F. Bateman, Dr. B. N. Carter, Dr. Stanley Dorst, Dr. Joseph Ganim, Dr. Ralph W. Good, Dr. L. Howard Schriver, Dr. E. B. Shewman, Dr. Charles T. Souther, Dr. Frank E. Stevenson and Dr. David A. Tucker, Jr.

The presentations will start at 8:30 a. m. and close at 12:30 p. m.

At the time *The Journal* went to press, the program of clinics had not been completed. However, a complete schedule of the clinics will be available on Tuesday evening, October 1, and Wednesday morning, October 2, at the Headquarters Desk at the Netherland Plaza and at the office of the Cincinnati Academy of Medicine.

Clinics will be held at the following hospitals: Cincinnati General, Children's, Good Samaritan, Christ, Jewish, Bethesda, Deaconess and St. Mary's.

The following tentative and incomplete list of clinics offers some idea of the scope and excellency of the presentations being arranged:

GENERAL HOSPITAL

8:30 A. M.—

Surgical Operative Clinic:

General Surgery.

Cholecystectomy. Dr. Max Zinninger.

Extra-pleural Thoracoplasty. Dr. B. N. Carter.

Thyroidectomy. Dr. Mont R. Reid.

9:00 A. M.—

Gynecology Clinic:

Gynecological Operations. Dr. V. S. Roberts.

9:45 A. M.—

Medical and Pediatrics Clinic Sponsored by General and Children's Hospitals; Surgical Amphitheater, General Hospital.

1. Medical Diagnosis. Dr. Marion A. Blankenhorn.
2. A Discussion of Cardiac Problems of the General Practitioner. Dr. Johnson Maguire.
3. Dermatological Cases of Particular Interest. Dr. Leon Goldman.
4. The Problem of Peripheral-Vascular Diseases. Dr. Louis G. Herrmann and Dr. Edward McGrath.
5. A Discussion of the Thymus Gland. Dr. A. Graeme Mitchell.
6. The Diagnosis of Scurvy. Dr. Waldo Nelson.

10:00 A. M.—

Orthopedics Clinic.

A Presentation of Several Interesting Cases. Dr. Joseph A. Freiberg.

DEACONESS HOSPITAL

10:00 A. M.—

Dry Clinics

A Demonstration of the Use of the Laryngostroboscope. Dr. S. H. Portney.

10:30 A. M.—

A Demonstration of the Management of Peripheral-Vascular Diseases with the Aid of the Passive Exercise Machine. Dr. R. W. Good, Dr. B. R. Sackler, Dr. A. Fleming, and Dr. S. Weinstein.

Special Telephone Service Is Arranged for Those Attending Cincinnati Annual Meeting

SPECIAL arrangements have been made by the Cincinnati Academy of Medicine for a private telephone hook-up between the Cincinnati Academy of Medicine Office switchboard and the Netherland Plaza for the convenience of physicians attending the 89th Annual Meeting, October 2, 3 and 4.

All sessions of the meeting will be held at the Netherland Plaza.

The Academy switchboard is operated on a 24-hour schedule.

Physicians attending the meeting may arrange to have all calls from their offices or homes relayed to them by means of this service.

Such service can be obtained by having the calls routed through PARKWAY 2345, the telephone number of the Cincinnati Academy Office.

Alumni of Northwestern University Medical School attending the 89th Annual Meeting of the Ohio State Medical Association at Cincinnati, will have a reunion dinner, Wednesday, October 2, 6:00 P. M., at the Netherland Plaza. Dr. H. M. Lowell, Hamilton, is in charge of arrangements.

ANNUAL REPORT OF THE COMMITTEE ON PUBLIC POLICY

J. H. J. UPHAM, Chairman, (1937) ..... Columbus
C. W. STONE, (1935) ..... Cleveland
JOHN B. ALCORN, (1936) ..... Columbus
JOHN A. CALDWELL, (ex-officio) ..... Cincinnati
R. R. HENDERSHOTT, (ex-officio) ..... Tiffin
C. L. CUMMER (special) ..... Cleveland
H. M. PLATTER (special) ..... Columbus
D. C. HOUSER (special) ..... Urbana
CHARLES S. NELSON, Secretary ..... Columbus

MORE changes are occurring at the present time in methods of medical practice and in the relations between the medical profession and the public than have taken place during any previous period in the history of the Ohio State Medical Association.

For that reason, the serious problems confronting organized medicine have multiplied greatly during the past year, and will continue to do so.

Needless to say, this situation has added to the responsibilities and necessitated increased activities on the part of the Committee on Public Policy, which during the past 12 months has been called upon to give more time and consideration to a greater number of difficult questions than in previous years.

This is substantiated by the following review of some of the more important activities participated in by the committee since the last Annual Meeting.

In passing, it should be noted that all members of the committee have given generously of their time and devoted much thought to the important matters coming before the committee.

We have received the wholehearted cooperation of all the officers, the members of the Council, and the personnel of our State Headquarters Office.

We have received, and deeply appreciate, splendid assistance from the majority of the officers and committeemen of the component county medical societies and academies, and a large number of the individual members of the State Association.

The committee has established and re-established valuable contacts with many other organizations mutually interested in medical and public health questions. We have initiated activities designed to build up good will and interest among the laity in the problems of the medical profession, and have sought in every way to safeguard the health of the public and protect the interests of the medical profession of the state.

In this report we have endeavored to summarize a few of the questions that have been considered by the committee and offer a few brief comments on anticipated problems.

Shortly after the Annual Meeting in the Fall of 1934, the Committee on Public Policy began preparations for the regular session of the 91st General Assembly which convened in January of this year.

The Legislative Reference Handbook was completely revised. Copies of it were sent to the officers of the local medical societies, legislative committeemen and the newly-elected members of the State Legislature. It contained a compilation of the policies of organized medicine on health and medical questions, as well as social, economic and governmental questions affecting medical practice and scientific medicine.

Through our State Headquarters office bulletins were issued frequently to the local legislative committeemen previous to, during, and following the regular session of the General Assembly, in addition to numerous personal letters on legislative matters.

PROBLEMS OF GOVERNMENT AND LEGISLATION

The legislative session which opened in January, 1935, was one of the most difficult, as well as most important ever held in this state. More than three-fourths of the members of the General Assembly were first-termers. Their attitude and viewpoints on medical and public health questions were in many instances unknown.

Our difficulties were muliplied as a result of the general feeling of unrest and demand for experimentation among a large group of the public which was reflected among some members of the Legislature.

Taking advantage of this situation and the fact that the personnel of the General Assembly included a large bloc of radicals, the cultists and anti-medical groups made desperate efforts to force through the Legislature proposals which would have destroyed the safeguards to public health and brought about a chaotic condition in statutory regulation of medical practices in Ohio.

Despite the political pressure these groups were able to exert on some members of the General Assembly and the activities of their well-paid lobbies, the committee, with the assistance of the local legislative committeemen, plus splendid cooperation and effective activity on the part of our State Headquarters personnel, was successful in bringing about the defeat of their dangerous proposals.

Several pieces of constructive medical and public health legislation which had our active support were enacted, including the Uniform Narcotic Drug Act; the bill making it mandatory that all public health nurses be registered nurses; one establishing a system of providing compensation and medical care for persons disabled while employed on work relief projects; a measure permitting probate and juvenile courts to provide emergency medical care for wards of the court;

a bill to require the state to pay for the care of the insane while in a detention hospital; a drivers' financial responsibility law.

Complete accounts of the last legislative session, including forecasts of future legislative problems, have been published in *The Journal*, especially in the June and July, 1935, issues, and should be considered a part of this report.

As pointed out in *The Journal* following the regular session of the Legislature, no legislation detrimental to public health or the interests of scientific medicine was enacted.

However, we must warn the membership that the crisis on many legislative questions in which the medical profession is vitally interested is still to come.

A special session of the General Assembly sometime this Fall can be definitely anticipated. At that time the important task of revamping the present tax laws will be undertaken. Sentiment for the enactment of an income tax is strong. Some groups and individuals are demanding that the present retail sales tax law be amended to include a tax on *professional and non-professional services*, which would include medical services. A hard fight on the part of the medical profession will be necessary to prevent such an amendment.

Consideration of proposed changes in the Workmen's Compensation Law and its administrative set-up is scheduled for the forthcoming special session. Naturally, the medical profession will be vitally interested in proposed legislation of this character and must use its influence to help defeat proposals that would cripple the workmen's compensation system.

When the Legislature reconvenes it may take action on measures to establish in Ohio a social insurance program, including unemployment insurance, extension of old age pensions, and possibly, *compulsory state health insurance*. Action on legislation of this character was postponed by agreement during the regular session of the General Assembly pending the outcome of the Social Security Bill in Congress which has now become law.

Obviously, continued activity and renewed interest in legislative affairs on the part of the members of medical organization are imperative. We cannot emphasize this too strongly. Future legislative sessions promise to be the most critical in the history of the state. We must be prepared. We must work in unison. Every member must be ready to do his bit. Every county society must have the best possible man in charge of its legislative activities. Contacts with members of the Legislature should be maintained. Friendly relations with other groups and organizations should be established in order that they will be familiar with the concerted viewpoint of the medical profession on some of the questions previously mentioned and can be counted on for assistance. Contacts should be constantly maintained between the local medical societies and our State Headquarters Office. Correspondence from that office on legislative matters should be answered promptly. Pertinent information on local legislative situations and developments should be sent to us through that office. We must keep our legislative machinery operating at high speed and coordinate our activities in such a way that we will be prepared to swing into action on short notice. We earnestly solicit the active interest and cooperation of every member in the work we are doing for the membership at large. Without these we can accomplish little and the interests of all will suffer.

MEDICAL CARE FOR INDIGENTS

Many new and difficult problems in connection with providing medical care for indigents and those on the relief rolls of the state and Federal governments arose during the past year, calling for an unusual amount of activity on the part of the Committee on Public Policy.

There are several phases of this question, which will be discussed briefly.

At the 1934 meeting of the State Association, the House of Delegates in effect instructed the Council and the Committee on Public Policy to confer and cooperate with the Ohio Hospital Association which was contemplating the drafting and introduction in the Legislature of a bill amending the poor laws of the state to place the responsibility of providing medical and hospital care and remunerating physicians and hospitals in the hands of local public health departments. (November, 1934, issue *The Journal*, page 739 and page 748).

In December, 1934, several conferences were held by the Committee on Public Policy and the Legislative Committee of the Ohio Hospital Association. The proposed bill of the hospital association was carefully analyzed. After thorough consideration and with the consent and approval of the Council (page 38, January, 1935, issue *The Journal*), this committee submitted to officials of the Ohio Hospital Association recommendations for modification in and additions to the proposed bill. Among the principles set forth were: (1) Maintenance of free choice by the needy patient of his own physician; (2) definite provision for payment to physicians for medical service rendered to the needy, whether such service is rendered in the home, office or hospital; (3) no definite stipulated fee schedule should be written into the bill; (4) provision should be made for an adequate budgetary allowance for health departments to defray the costs of administration of the proposed law; (5) provision should be made that all health commissioners must be physicians in good standing in their profession.

The proposal was amended to include these recommendations. However, before it could be introduced in the Legislature, opposition developed among a number of the larger hospitals of the state, especially with respect to the provision for payment of physicians for medical services rendered indigents while in the hospital. As a result of this difference of opinion within their own ranks, officials of the hospital association did not have the measure introduced in the State Legislature. Because the legislative session was well underway before this decision was reached, no opportunity was offered for the introduction of any other measure to improve and modernize the provisions of the poor laws relating to medical care of indigents.

NEGOTIATIONS WITH THE FERA

The second problem in connection with medical care of the needy involved extensive negotiations with FERA officials in Ohio and resulted in material improvements in the medical relief program established in the Fall of 1933.

Difficulties which had arisen shortly after the medical relief program was inaugurated in Ohio under FERA Rules and Regulations No. 7 reached a critical stage last Spring. Due to controversies between the state administration and FERA officials at Washington, inadequate funds for medical care, and the inflexibility of some of the medical relief regulations, physicians' bills for services to those on relief were being drastically pro-rated and in many instances payment of pro-rated bills delayed for an unreasonable length of time. Physicians in all parts of the state protested vigorously this unfair treatment and in some communities threatened to refuse to participate in the medical relief program unless adjustments were made.

A conference was arranged by the Committee on Public Policy with Mr. W. A. Walls, state relief administrator, (March, 1935, issue *The Journal*, page 219 and April, 1935, issue, page 279), and his successor, Mr. C. C. Stillman, appointed by the FERA to handle relief activities in Ohio (May, 1935, issue *The Journal*, page 364).

The net result of these preliminary conferences was that for the first time the State Medical Association, officially representing the medical profession of the state, was granted the right and privilege of assisting and cooperating with the relief officials in revising the medical relief program.

Acting on the instruction of the Council, the Committee on Public Policy sent a questionnaire to every county medical society and academy of medicine in order to secure accurate data on the medical relief situation in all parts of the state. Valuable information was obtained from other states. Numerous informal conferences were held by relief officials, members of this committee, and members of our Headquarters Office staff.

The committee, after a thorough consideration of the question, submitted a suggested revised set of rules and regulations, together with many supplemental recommendations, to Mr. Stillman. (June, 1935, issue *The Journal*, page 453).

Following another joint conference, Mr. Stillman authorized modification of the rules and regulations governing medical care of those on relief in line with some of the important recommendations made by the State Medical Association. (July, 1935, issue *The Journal*, page 528).

The revised regulations became effective July 1 and included provisions for more funds for paying physicians' bills; separation of the costs of drugs and medical supplies from the costs of professional services; establishment of a medical advisory committee in each county; definite instructions relative to the care of chronic illnesses; and more stringent regulations pertaining to authorizations for special services, special supplies, etc.

Your committee regrets that the relief officials could not see their way clear to accept all the recommendations submitted by it, especially that eliminating the provision limiting expenditures for medical care in any one month to a definite amount. Also, we regret that shortly after the revised regulations became effective, the Federal Government made drastic reductions in direct relief funds allocated to Ohio which nullified some of the good results attained through revision of the medical program.

We take this opportunity to pay our respects to Mr. Stillman and his aides for their cooperative attitude and sympathetic understanding of the problems of the physicians of the state. We are optimistic enough to believe that they will be as liberal as possible in medical relief matters and go as far as their authority permits.

Moreover, we desire to express our sincere appreciation of the splendid assistance accorded us by the officers of most of the county medical societies and others who furnished us with information and recommendations on the medical relief situation. Without active support on the part of the county societies and various individual physicians throughout the state, we would have been severly handicapped in our negotiations with FERA officials.

There is considerable uncertainty about the future of poor relief activities in Ohio. The situation has changed so rapidly that it has been difficult to develop plans and activities with any degree of certainty or broad enough to meet unanticipated problems.

The Federal Government has announced its intention to withdraw from the field of direct relief as soon as the new Works Progress program gains momentum, and return to the states or local subdivisions the responsibility of caring for those

unable to secure employment in private industry or on Federal works projects.

No one is able to say at this time how direct relief, including medical care of the indigent, will be administered in Ohio when this takes place.

We are watching developments closely and will make every effort to see that proper provisions are made to provide compensation for physicians for their services to those financially unable to provide medical care for themselves and their families.

It is hoped that every county medical society has by this time formed a strong medical advisory committee in cooperation with the relief director of the county. This committee can be of great service no matter what type of medical program is established in the future. It can assist the local relief director in providing medical care for those injured on work projects. It will be ready to act as a contact unit between the local medical profession and local governmental officials when the responsibility of providing all types of relief for the poor is returned to local authoirties. Many of these medical relief problems are local in scope and character and must be solved through local contacts and conferences. This will be especially true when, and if, administration of poor relief again becomes a local responsibility. This committee will be ready at all times to assist all county societies. We will keep in constant touch with developments in Columbus. We will not be able to perform miracles but we hope to impress on those in charge of relief activities the fact that adequate provisions must be made for medical services to the poor, whether the set-up is on a Federal, state or local basis.

MINIMUM FEE SCHEDULES

To clarify the policy of the State Association as to the advisability and legality of official minimum fee schedules by county medical societies, the Council at its July, 1935, meeting (September, 1935, issue of *The Journal*), adopted the following statement prepared by the Committee on Public Policy and submitted for Council action:

In correspondence and otherwise, the advice of the Committee on Public Policy has been sought relative to the advisability and legality of action on the part of county medical societies in establishing minimum standard fee schedules for medical services to indigents.

Also, the committee has been requested to consider the possibility of sponsoring legislation to amend the present Poor Relief Laws and make mandatory the payment of medical fees by county, township and municipal officials which are commensurate with the services rendered by physicians

After much study of these questions and reviewing existing policies of the State Association bearing on them, the committee herewith presents to the Council for consideration and action the following recommendations to guide the component county medical societies in their negotiations with local poor relief officials:

1. It is desirable and important that frequent conferences be held by the representatives of medical organization and county, township and municipal poor relief officials, in an effort to establish local medical relief programs mutually agreeable to physicians, relief officials and indigent patients.

Upon authorization of the county medical society, the representatives of the society should be prepared to suggest to relief officials minimum fees for various types of medical services rendered the indigent and should endeavor amicably to reach an agreement with relief officials that insofar as practicable and feasible, the suggested fees will be paid by such officials to compensate physicians for their care of the poor.

However, it is recommended that county medical societies avoid any official action that could be interpreted or construed to mean the adoption of an official standard fee schedule or as an attempt to coerce individual physicians into adhering to such suggested fees in the presentation of bills to relief officials.

It is believed that such action on the part of a county medical society might lead to legal difficulties or embarrassment. Doubtless it would be misunderstood by that portion of the public able and willing to pay the prevailing customary fees for medical care.

In the final analysis, we fear that any attempt on the part of a county medical society to standardize medical fees through compulsion or threat of disciplinary action might be construed as a violation of Section 6391 of the General Code of Ohio and believe that such action would be in conflict with the inherent right of every physician to exercise his own judgment in professional matters so long as his actions are in conformity with existing legal requirements and in accord with sound public policy and medical ethics.

The wise and safe policy for each county medical society to pursue is to establish through frequent conferences and cooperative efforts, friendly relations with poor relief officials and subsequently convince such officials of the justness of fairly compensating physicians for their services to recipients of poor relief.

2. Ohio's present poor relief statutes are inadequate and antiquated. They should be modified, supplemented and recodified. The provisions pertaining to medical care of the poor are ambiguous and incomplete. Medical organization, we believe, should lend its support to constructive efforts to revise and recodify these statutes.

However, we are opposed to insertion in the poor relief statutes of a definite state-wide medical fee schedule governing physicians' services to the indigent, or reference to fee schedules established by administrative order.

Standardization of medical fees through legal enactment for services to the indigent would in all probability lead the public to believe that such fees constitute the "legal fees" for private practice. Litigation and embarrassment would result. Obviously, it would be difficult to maintain fees for private practice on a level comparable to the ability of the private patient to pay for the services received from his private physician.

It is impractical and not feasible to apply a standard fee schedule for the entire state. Fees should be adjusted locally with the customary fees charged in the respective locality as the basis for negotiations. This is consistent with the previous

policy of the State Medical Association and should be adhered to.

MEDICAL CARE FOR RECIPIENTS OF OLD AGE PENSIONS

At the request of H. J. Berrodin, chief of the State Division of Aid for the Aged, and following communications from members in various parts of the state, the Committee on Public Policy made a careful study of matters of policy with respect to the question of providing medical care for recipients of old age pensions.

Information secured by the committee showed that an allowance of $1 for medical care is carried in the monthly budget of those receiving old age pensions. However, this amount is included in the total pension paid by the state and there is nothing to prevent the $1 per month from being spent by the pensioner for other necessities. The information reviewed by your committee indicated that many of those receiving pensions are unable to pay for medical services out of their monthly dole and that doubtless only a comparatively few would have the inclination to do so even if their annual income permitted.

After a thorough consideration of all angles involved in this question, the Committee on Public Policy submitted a report to the Council, setting forth a policy on this problem which was officially adopted by The Council. (July, 1935, issue *The Journal*, page 530). The principles contained in that statement of policy were in effect as follows:

That no special fund be allocated to or established in each county to provide medical care for recipients of old age pensions for the reason that the establishment of an additional system of medical service under governmental control such as that is unnecessary and inadvisable.

That those receiving old age pensions should be classed as permanent indigents and that any supplemental relief, including medical care, required by them should be provided by local subdivisions charged with the responsibility of providing relief for this class of indigents in accordance with present poor relief statutes.

That recipients of old age pensions, if unable to provide medical care for themselves and unable to make satisfactory arrangements with their family physicians, should be cared for in already-established clinics, dispensaries or other local charitable facilities.

That the State Division of Aid for the Aged be requested to base its policy on medical services on the foregoing principles and a special effort be made to arrange for medical care for such persons under the FERA medical relief program, providing their monthly pension is insufficient to meet their budgetary requirements.

POLICY ON MOTOR VEHICLE INJURY CASES

During the past several years, the State Association has been requested by some of its members to initiate and sponsor proposed legislation to provide for reimbursement of physicians for the care of indigents injured in motor vehicle traffic accidents as a part of the present set-up which provides compensation to hospitals for services to such persons out of State Highway Maintenance and Repair Fund.

The Council, with the approval of the Committee on Public Policy, has declined to endorse or support a proposal of this character. (January, 1933, issue *The Journal*, page 46, and January, 1935, issue, page 38).

It has been felt that it would be inconsistent to support a proposal for centralized, governmental medicine for one type of disability and to continue to oppose general socialization of medicine; that the medical profession was divided in its attitude on this question; that there is a definite constitutional question concerning the legality of the diversion of highway maintenance and repair funds for hospital and medical services; that serious difficulties would be encountered in promoting such legislation which might weaken the position of the medical profession with members of the Legislature on other much more important legislation; that these cases are relatively few and entirely incidental to the large problem of medical care to the needy generally and that our efforts should be concentrated on securing improvements in the general laws relating to medical care of the poor; that such legislation might open up the field of governmental medicine for others than those actually in need, due to the loosely-worded definition in the hospital compensation act of the term "indigent"; and that local subdivisions, through regular relief departments, rather than the state, should reimburse physicians for services to all indigents, whether suffering from injuries received in automobile accidents or other physical disabilities.

Inasmuch as this question has been raised comparatively recently by some members, it was presented to the Council again for consideration at its meeting in July of this year. (September, 1935, issue of *The Journal*). The Council at that time made no modification of the existing policy, as summarized above, and instructed this committee to continue its study of proposed legislation of this character.

MISCELLANEOUS ACTIVITIES

To give the membership some idea of the variety and multiplicity of the activities of the Committee on Public Policy during the past year and citations that may be of assistance in determining what the official policy or action of the State Association has been on numerous questions, we have summarized some of the work done by the committee in addition to that already outlined.

Retail Sales Tax Law. Shortly after the Ohio Retail Sales Tax Law was enacted late in 1934

by the Ohio Legislature, considerable confusion arose as to the effect of the law on physicians and others engaged in professional pursuits, despite the fact that "professional or personal service transactions which involve sales as inconsequential elements for which no separate charges are made" were particularly exempted. The preliminary regulations issued by the State Tax Commission were not clear on whether or not a physician would have to collect a sales tax; whether a physician should be classified as a "vendor" or a "consumer", etc. Several conferences were held with officials of the Tax Commission. We were successful in getting the Commission to revise its initial ruling applying to sales to and by physicians. The new regulation clarified the situation, specifically classified a physician as a consumer although he might be engaged in dispensing drugs and medical supplies as a part of his professional service and in connection with his examination of patients, and exempted him from collecting the retail sales tax and securing a vendor's license. We have failed so far to convince the Commission that an oculist who furnishes glasses to his patient should be exempted from collecting the tax on the glasses providing he is willing to pay the optician the tax at the time the glasses are delivered to him. Future conferences on this question are contemplated. For detailed information on the sales tax question, we suggest the members refer to the February and March, 1935, issues of *The Journal*, page 128 and page 209, respectively.

Sherrill Government Survey. Several conferences were held by the committee with representatives of the special commission appointed by the Governor, and headed by Colonel C. O. Sherrill, to make a survey of the state government and submit recommendations for greater economy and efficiency in administration of various state departments, boards, commissions, etc. Considerable information was furnished by us to the sub-committees surveying the State Department of Health and the various state examining and licensing boards, including the State Medical Board. A cooperative relationship was established and we made forceful presentations of the policy and attitude of organized medicine on questions raised in connection with the survey.

Cooperation with A.M.A. and Committee on Medical Economics. The Committee on Public Policy has on many occasions during the past year assisted the American Medical Association Headquarters Office in securing pertinent data in Ohio on numerous important questions. We have carried out the suggestions of the A.M.A. relative to disseminating information on social, economic and governmental questions to the physicians of Ohio and keeping Ohio's delegation in Congress supplied with accurate data and the concerted viewpoint of the medical profession of this state on Federal legislative proposals. We have cooperated with and assisted the Committee on Medical Economics of the State Association in its consideration of and action on economic and social questions of importance to the profession generally.

Other Contacts and Activities. Your committee has held numerous conferences with allied professional groups and industrial and business organizations on matters of mutual interest, including the Ohio State Nurses' Association, Ohio State Dental Association, Ohio State Pharmaceutical Association, Ohio Manufacturers' Association, Ohio Chamber of Commerce, etc. We have frequently conferred with officials of the State Department of Health and cooperated with that department on various matters.

GREATER PUBLIC ACTIVITY IMPERATIVE

In conclusion, we would like to emphasize the necessity for greater public activity on the part of medical organization and physicians as individuals. Many of the problems confronting the medical profession are local in scope and effect. These must be met by concerted action on the part of local medical societies. The public is not accurately and fully informed on the medical viewpoint of many of the social and economic aspects of medical practice and medical service. It is the obligation of medical organization, through alert and active public relations committees, to furnish the laity with correct information. Arrangements should be made by all county medical societies to make speakers available for civic groups. Those circulating propaganda detrimental to our interests are on the job constantly. We must counter with vigorous activity and do everything possible to promote the policies of organized medicine. Much is being done by the various committees of the State Association and our Headquarters Office, but this is not enough. Local activity is essential and there must be coordination throughout the state as a whole. Organized medicine can be a powerful factor in promoting the public welfare and in safeguarding the interests of the medical profession if we develop greater teamwork and more aggressive activity.

—OSMJ—

When a county wishes to establish a county health department under the provisions of the Waldvogel Act, the proposal requires the votes of only a majority of those voting on it, according to a recent ruling of Attorney General John W. Bricker.

The ruling was requested by State Health Director Hartung. The Waldvogel Act was one of the County Government Commission measures enacted at the last session of the legislature.

ANNUAL REPORT OF THE COMMITTEE ON MEDICAL ECONOMICS

L. L. Bigelow, Chairman, (1937).....Columbus
J. Craig Bowman, (1936).....Upper Sandusky
E. O. Smith, (1935), deceased.....Cincinnati
B. J. Hein, Special ex-officio.....Toledo

THE era of experimentation that has come upon us which undertakes to establish by executive fiat a new social and industrial order, has given tremendous impetus to the efforts of those reformers who feel that socialism or communism is the "way out", and find in medicine the Achilles heel through which their attack is most likely to succeed. The accident of accident or disease is not the fault of the individual. Why should he be penalized for mishaps of this sort and be required to pay out money for relief that otherwise might purchase tobacco, cosmetics, radios, automobiles, amusements and those other objects of "optional consumption", which no committee through endowed financing seeks to muckrake and shackle? Why should he indeed? This line of argument is readily accepted by that increasing number of individuals who find it easy and pleasant to exchange their votes for release from responsibility and for the shelter of paternalism. Hypodermics of this sort administered repeatedly in increasing doses will as inevitably enfeeble and finally destroy the moral backbone of the social body as surely as the use of morphine will destroy the manhood of a patient who lacks the courage to face the stern realities of his situation.

Lowered or lost incomes and dissipation of resources because of the prolonged depression have brought new hundreds of thousands to the below-comfort level where medical care at the normal rates is clearly beyond their means. The gratuitous care of the indigent poor has been a social contribution made by the medical profession that has come to be accepted in a matter-of-fact way. The sudden and tremendous increase in this load, brought on by the depression, has compelled attention to the economic problem of getting medical care to those who need it at rates they can pay. Obviously, the doctor who has taken on himself as a traditional obligation the medical care of the sick poor, could not maintain his economic existence if he were obliged to add to that already heavy burden the care of those whose altered status makes it impossible for them to pay the normal customary fees, although they were able to pay some part of them. How to get medical care to these large groups temporarily unable to meet their medical obligation at the normal level, has been the subject of study and experimentation at many points throughout the United States. Over two hundred plans have been considered or are in operation, differing in details of set-up, operation and management, but having a common object of distributing medical care in a manner that will not be burdensome to the patient and will bring some revenue to the doctor, and a common danger also that the reduced rates may become established in the public mind as normal rates in normal times.

Great confusion exists in the public mind relative to the medical aspects of social and economic theories and plans offered for public consumption by lay groups, governmental agencies, and occasionally by members of the medical profession.

Some physicians are not fully informed about critical problems confronting the medical profession, largely because they refuse to read authentic data disseminated to them through the channels of organized medicine.

For that reason, too many physicians do not comprehend the seriousness of present-day social and economic changes from the standpoint of their possible effect on the practice of medicine and medical care, and are unprepared to discuss these matters convincingly with their colleagues and acquaintances among the laity. It is vitally important, therefore, for medical organization to maintain active and alert committees on economics and public relations, to carry on effective educational activities among both physicians and laymen.

The chief aim of the Committee on Medical Economics of the State Association during the past year has been to carry on this educational campaign.

FINAL DECISION UP TO LOCAL SOCIETIES

We believe the function of this committee is to evaluate plans and proposals that provide for the distribution of medical care on a new basis and to offer advice. The committee, however, does not commit itself to any one proposition or program, believing that final decision should rest with the component units of the state society, which are in a better position to analyze local conditions and needs, and adopt methods best suited to meet them.

In order actively to assist the membership, the Committee on Medical Economics has made a study of many of the experimental medical service plans now in operation or proposed; it has endeavored to classify these plans, and in many instances has analyzed them from the standpoint of public policy and the policies of the Ohio State Medical Association.

At frequent intervals, information secured by the committee has been submitted to the Publication Committee and published in *The Journal* where it has been available for all members. The data assembled by the committee have been in-

corporated in special bulletins and they have been of great value to our Headquarters Office in answering inquiries from members and others.

The committee has furnished the Bureau of Medical Economics of the American Medical Association facts and figures on economic and social conditions in Ohio and with information on the efforts made by organized medicine in this state to bring about readjustments that will insure adequate medical care for all and at the same time safeguard the interests of the medical profession.

A. M. A. BUREAU IS COMMENDED

The committee desires to pay tribute to the splendid work being done by the Bureau of Medical Economics of the A. M. A. This bureau has now in its files the most complete and authentic collection of material on economic and social questions affecting medical practice ever assembled. It has published much valuable material on sickness insurance and related subjects which is available to physicians upon request. Included in its list of bulletins and pamphlets are the following: A Critical Analysis of Sickness Insurance; A Handbook of Sickness Insurance, State Medicine, and the Costs of Medical Care; Sickness Insurance Not the Remedy; Contract Practice; New Forms of Medical Practice; Health Insurance in England and Medical Society Plans in the United States; Group Hospitalization Contracts are Insurance Contracts; Prepayment Plans for Hospital Care; Sickness Insurance and Sickness Costs; Sickness Insurance Catechism; and Special Report on Existing County Medical Society Plans.

The chairman of the committee, at the request of the Council, attended last Spring in Chicago, a conference of representatives of medical organization from all parts of the country, called by the American Medical Association; at which numerous problems in the field of medical economics were discussed. He submitted information on activities being carried on in Ohio and secured valuable data on activities in other states to add to material which already had been assembled by the committee.

WEALTH OF DATA ASSEMBLED

To summarize, through the efforts of the Committee on Medical Economics, the files of our State Headquarters Office have been supplied with material of great value on almost every phase of the social-economic side of medicine. This information is available to any member upon request. In addition, there is the gigantic collection of the American Medical Association as a source of supply. It may, therefore, here be stressed that there is little excuse for a physician to be misinformed or uninformed on these vital questions, or unprepared to discuss them intelligently with colleagues, patients, friends or acquaintances.

After a thorough analysis of scores of new plans and proposals dealing with the distribution of medical service and a consideration of them from the standpoint of scientific medical value, public benefit and conformity to sound social and economic concepts, your committee was impressed by the dangers inherent in many of them. It feels obligated, therefore, to warn the profession to act cautiously and on full information before definitely, or by inference, committing itself to new and experimental methods for the provision of medical care to indigents or to those financially able to provide such service for themselves.

FUNDAMENTAL PRINCIPLES REITERATED

The committee sees no need for a modification of the attitude of the State Medical Association toward sickness insurance, the socialization of medicine and the various medical service plans that are being proposed. The official views of the State Association are doubtless well known. The ten cardinal principles adopted by the House of Delegates of the American Medical Association in June, 1934, to govern the practice of medicine and to serve as the basic requirements in all plans for the distribution of medical care express the considered opinion of the medical profession at large. They conform with policies previously adopted by our Association; they have been officially endorsed by our House of Delegates; and they are here reproduced for the guidance of any county society which may have under consideration a new plan for the distribution of medical care.

1. All features of medical service in any method of medical practice should be under the control of the medical profession. No other body or individual is legally or educationally equipped to exercise such control.

2. No third party must be permitted to come between the patient and his physician in any medical relation. All responsibility for the character of medical service must be borne by the profession.

3. Patients must have absolute freedom to choose a duly qualified doctor of medicine who will serve them from among all those qualified to practice and who are willing to give service.

4. The method of giving the service must retain a permanent, confidential relation between the patient and a "family physician". This relation must be the fundamental and dominating feature of any system.

5. All medical phases of all institutions involved in the medical service should be under professional control, it being understood that hospital service and medical service should be considered separately. These institutions are but expansions of the equipment of the physician. He is the only one whom the laws of all nations recognize as competent to use them in the delivery of service. The medical profession alone can determine the adequacy and character of such institutions. Their value depends on their operation according to medical standards.

6. In whatever way the cost of medical service may be distributed, it should be paid for by the

patient in accordance with his income status and in a manner that is mutually satisfactory.

7. Medical service must have no connection with any cash benefits.

8. Any form of medical service should include within its scope all qualified physicians of the locality covered by its operation who wish to give service under the conditions established.

9. Systems for the relief of low income classes should be limited strictly to those below the "comfort level" standard of incomes.

10. There should be no restrictions on treatment or prescribing not formulated and enforced by the organized medical profession.

POLICY OF ORGANIZED MEDICINE CLARIFIED

In February, 1935, a special session of the House of Delegates of the American Medical Association was held in Chicago for the purpose of clarifying the position of organized medicine on social and economic developments affecting medical practice. Ohio was represented at that gathering. Official action was taken, which your committee believes should become a part of the official policy of the Ohio State Medical Association. The resolution adopted at the Chicago session reads in part as follows:

"The House of Delegates of the American Medical Association reaffirms its opposition to all forms of compulsory sickness insurance whether administered by the Federal government, the governments of the individual states or by any individual industry, community or similar body. It reaffirms, also, its encouragement to local medical organizations to establish plans for the provision of adequate medical service for all of the people, adjusted to present economic conditions, by voluntary budgeting to meet the costs of illness.

"The committee has studied this matter from a broad standpoint, considering many plans submitted by the Bureau of Medical Economics as well as those conveyed in resolutions from the floor of the House of Delegates. It reiterates the fact that there is no model plan which is a cure-all for the social ills that affect mankind. There are now more than 150 plans for medical service undergoing study and trial in various communities in the United States. Your Bureau of Medical Economics has studied these plans and is now ready and willing to advise medical societies in the creation and operation of such plans. The plans developed by the Bureau of Medical Economics will serve the people of the community in the prevention of disease, the maintenance of health and with curative care in illness. They must at the same time meet apparent economic factors and protect the public welfare by safeguarding to the medical profession the functions of control of medical standards and the continued advancement of medical educational requirements. They must not destroy that initiative which is vital to the highest type of medical service.

"In the establishment of all such plans, county medical societies must be guided by the ten fundamental principles adopted by this House of Delegates at the annual session in June, 1934. The House of Delegates would again emphasize particularly the necessity for separate provision for hospital facilities and the physician's services. Payment for medical service, whether by prepayment plans, installment purchase or so-called voluntary hospital insurance plans, must hold, as absolutely distinct, remuneration for hospital care on the one hand and the individual, personal, scientific ministrations of the physician on the other."

In compliance with the request of the A. M. A. House of Delegates at its special session, the Bureau of Medical Economics of the A. M. A. made a comprehensive study of nearly 200 different experiments being conducted or considered by county medical societies throughout the country. A report on this study was presented to the A. M. A. House of Delegates in Atlantic City last June. Following careful consideration, prolonged discussion, and some modification, it was approved and adopted to supplement the existing policy of organized medicine.

WARNINGS SOUNDED IN SPECIAL REPORT

The report pointed out that medical societies are not only discussing these problems but are striving earnestly to improve conditions; the medical profession has recognized its responsibility and has accepted its position of leadership in providing medical service.

It is impossible here to summarize the analysis made in the Bureau's report of the various plans in operation. The report has been published and is available to all members upon request.

However, the following sections are quoted because they contain much sound advice and elaborate on existing policies. The committee is of the opinion that these statements of principles and policies should receive official recognition as a guide to the profession in this state:

"There is no model plan which is a cure-all for the social ills any more than there is a panacea for the physical ills that affect mankind. Moreover, it will be found after careful and honest examination of the needs of some communities that a *plan* is neither necessary nor desirable. Furthermore, it may be predicted with confidence that as rapidly as economic recovery returns other communities will be added to the list not requiring any new or greatly modified methods for providing medical care.

"In nearly every country having sickness insurance, local conditions have forced modifications of the general plan. Whether the "plan" is one imposed by legislation or one devised and operated on standards set voluntarily by the medical profession, a single, universal or master plan cannot possibly be devised to meet all the varying conditions throughout the United States or even different sections of individual states.

"In designing and operating plans to provide medical care for the indigent and low income groups, county medical societies may well consider the dangerous, destructive and unethical tendencies which even the most carefully conceived and constructed plan may assume. Some of these may follow an incomplete or inaccurate preliminary estimate of the medical situation; some may result from the unpredictable factor of human nature; others may follow as the natural outcome of changes in the general economic conditions entirely beyond the control of the medical profession. Regardless of the causative factors,

which may vary in different communities, county medical societies must be prepared to recognize and deal with complications affecting the organization of medical care under the specifications of a county plan just as their members are trained to deal with complications which often occur to change the course of the diseases which they treat. Some of these dangers and complications are:

"1. The adoption and operation of a medical plan where it is unnecessary.

"2. The stimulus aroused by good plans among irresponsible organizers to develop and operate imitations and counterfeits.

"3. The establishment in medical practice of dangerous patterns following the adoption of undesirable types of plans.

"4. The compromise of medical societies in the corporate practice of medicine or in the operation of insurance companies as a result of an insufficient study of state statutes and case law.

"5. Failure, in the operation of a plan, to conform to the Principles of Medical Ethics.

"6. The almost inevitable transition of voluntary insurance plans into compulsory contributory sickness insurance systems operated by the state.

"7. The difficulties involved in or the failure adequately to provide for complete control of medical affairs by the medical profession.

"8. The 'freezing' of medical fees at a point below that which is consistent with good medical service.

"9. Failure to bear constantly in mind that a medical society plan is an experiment in the methods of distributing medical service and that it may have only a temporary usefulness, may need frequent or drastic modifications or may need to be discarded entirely.

"10. Medical society plans must not be considered or accepted as a substitute for the regular practice of medicine as applied to the majority of people. If it is believed such plans may be useful, they should be considered merely as supplementary facilities in the distribution of medical service. They should be used only so long and in such a manner as they serve efficiently to make more easily available to low income groups a high quality of medical care.

"Regardless of the sincerity of those who devise and operate a good medical plan, such a plan may only stimulate counterfeits promoted by irresponsible people. Competition between medical plans inevitably reduces the quality of the service and disturbs the public confidence.

"There is danger that in the effort to attract patronage to any plan the public may be educated to the false belief that good medical care can be furnished for too low sums. Even the most enthusiastic advocates of compulsory sickness insurance have been forced to recognize that it is not possible to furnish a good medical service for less than $30 per person per year, or somewhat in excess of $100 per family per year.

"There is always the grave danger of adopting an undesirable type of plan which it will be impossible to change later and which will become a pattern for wider plans in the future.

"It is important that all matters concerning medical services should be controlled by organized medicine. The medical profession cannot if it wished, and it certainly has no such wish, avoid the duties and responsibility for such control and leadership. It therefore certainly has the right to insist on exercising the corresponding direction of any activities concerning medical service.

"Legal advice is essential on all steps that may involve general or individual responsibility. This is especially true when some organization separate from the county medical society is set up.

"The principle of free choice of physicians is one that has been universally endorsed by the medical professions of all countries and proved by experience to be essential to good service. Any financial or other limits on admission to practice should not be of a nature to disbar any member of the county medical society who may desire to give service. Success depends on obtaining the cooperation of a large percentage of the membership. Any plan which divides a county medical society may do more harm than good.

"Essentially the task before the medical profession involves the old problem of furnishing one grade of medical service to all classes, some of which have incomes too low to permit them to pay the cost of such service. This problem is as old as the medical profession. The only solution that has ever been suggested is the sliding fee scale. This statement may be challenged, just as that method has been denounced, but an examination of proposed solutions provides the proof of the statement.

"The principle of payment for medical service by insurance is always made on this principle. Sometimes this goes into detailed adjustment by making the collection a percentage of income. If collections are restricted to certain income limits, this is claimed to deliver to the lower income classes a service equal to that for which the excluded higher income classes must pay a larger price. The practical result is often to give the classes included in the insurance scheme a poorer service and at a higher price. It is difficult to collect sufficient payments from the underpaid classes to permit the maintenance of a high grade of service, because of the cost of administration and the method of distribution. Lay valuation, domination and direction of the service further injure its quality.

"Even complete state medicine, unless all incomes have first been leveled to a common denominator contains the principle of the graduated price. Taxation will always distribute the burden in some degree proportionate to differences in incomes. While unequal incomes exist at the same time as equal needs, all methods existing or proposed for furnishing medical service must grade the cost according to income.

"Idealism is an essential part of medical service. A destruction of the motives of public interest and willingness to serve the unfortunate, which has always accompanied and been one of the chief glories of the medical profession, will strike at one of the most important elements in the giving of that service.

"Regardless of whether or not a plan to make medical service more easily available in a community is thought advisable, it is believed that the medical profession will never surrender or renounce that age-old privilege of relieving the suffering of those who are unable to pay.

"Since solutions of social questions and panaceas for economic evils are for the most part wishful thinking, which, when an attempt is made to apply them in practical life, give disappointing results, the question arises as to where progress is most easily possible and is likely to be most promising of results. The progress will be gradual—one step at a time. There is no other

kind of sane progress—no sudden jumps, and least of all in social changes. Institutions, traditions and the human beings that are products of thousands of years of gradual evolution are stubbornly resistant to change. This is no less a truism than the one that says that the only constant thing is constant change. Another truism usually forgotten is that when going anywhere one must start from where one is. Whatever changes take place will consist primarily of new arrangements of things now existing. Finally, to this collection of neglected truisms can be added that fact that one cannot successfully transplant from another country institutions bred of different social heredity and developed in a wholly different environment.

"It is necessary constantly to make clear and to emphasize that the basic problem of medical economics is one of adjusting the relations of two systems of economics in the same society. One of these, that based on the production, distribution and consumption of the vast mass of material commodities, rests on technologic mass production. Its products are subject to valuation by demand and supply in the bargaining of the market. The operation of this system has brought about a wide variation in incomes. It has also created a social solidarity in which there are many health problems common to the whole body of the people.

"Medical service is produced under quite different conditions. It is not dependent on technical evolution; mass production is not possible; value is not fixed by the conflict of the buyers and sellers in the market, but by professional standards and discipline, supplemented by legislation embodying those standards.

"The medical profession, in its professional associations, is the only possible body that can organize the supply and distribution of that service without harmful effects on, and possible destruction of, that service itself. This principle has already been accepted in all countries by the establishment of systems of licensure, medical education and other standards of medical service set up by the profession to protect the public. It is recognized in the decisions of courts restricting the furnishing of such service to those who have met professional standards and in the rulings that expert evidence concerning medical matters can be given only by those who have met such standards.

"This situation is not changed in any essential way by the fact that the progress of medical science and art has caused the creation of many subsidiary organizations and much mechanical and scientific equipment. All these things center around and are dependent on the medical profession. The 'point of production' of medical service is where the individual physician meets the individual patient. Hospitals are built and conducted to create the best possible environment for that contact. Laboratories are maintained to improve the conditions of that contact. Nurses, social workers and others concerned have a similar function.

"It therefore follows that in any plan to improve the adjustment of the relations between these two economies the medical profession must retain a central position in all that concerns the valuation and delivery of medical service. There is another practical reason why this must be true. While each of the other elements involved plays an important part, the common element without which no one nor all of them can function in the delivery of service is the physician. Just as he is the central and the essential element at the point of production of medical service, so he must exercise a position of leadership and control in any reorganization of the methods of giving that service. The profession needs, and will always welcome, the cooperation and advice of all elements affected in health problems but just as the individual physician must constantly assume the tremendous responsibility of decisions that involve life and death with individual patients, so the profession as a whole must assume the leadership and responsibility in the organization of medical service in the community."

COMMENTS OF GROUP HOSPITALIZATION

The picture would not be complete without brief mention of developments in group hospitalization. Interest in this movement has increased. For that reason the medical profession must be well informed on proposals of this character.

The State Medical Association has never taken a definite position for or against prepayment methods of providing hospital care, per se. However, it has warned the membership to proceed cautiously in acting on such proposals for reasons well explained at that time. (December, 1933, issue, *The Journal*, page 777).

The annual report of the Bureau of Medical Economics of the A. M. A. to the House of Delegates this year made some pertinent comments on group hospitalization. These should be taken into consideration by county societies when this question is before them for discussion and action. They were in part as follows:

"The nature of the contract is of vital concern to the medical profession. If hospitals are permitted to include medical services in their contracts for hospital care, the avenue is opened and the precedent is set for the practice of medicine by hospitals. Furthermore, it is possible that some hospitals that should be closed may, by the assistance of a group hospitalization scheme, continue to serve the public badly.

"At present there is a wide variation in the status of group hospitalization schemes. Some are being operated with the sanction and active assistance of county medical societies; others are being operated in communities in which the county medical societies maintain a position of non-interference but close observation; in some places the medical societies have succeeded in having hospitalization contracts drawn so as to exclude all medical services, while in other sections the group hospitalization contracts include varying amounts of medical services and thus make it possible at a later date to add more and more medical care under the guise of hospitalization. There is grave doubt that any group hospitalization schemes are using actuarily sound bases for premium rates.

"The theory of the insurance principle in the provision of hospital care appears to be sound, but in the application of this principle to hospitalization, as in the field of sickness insurance, numerous opportunities for perversion and abuse are offered and many of the dangers inherent in sickness insurance practice are introduced. The most important of these dangerous tendencies have already been mentioned; viz., failure to limit the contract coverage solely to hospital care, and

the possibility of keeping active some undesirable institutions that, for the public good, should be closed.

"The Bureau has a record of fifty-five group hospitalization plans that are now operating or have been discontinued. There are forty-four more plans that have been proposed but as yet are not operating."

FEDERAL SOCIAL SECURITY ACT

This committee has followed with some anxiety the activity of the Federal Government in sponsoring and promoting social insurance legislation and the developments pertaining to the passage of the Social Security Act by the U. S. Congress.

Considerable information on this subject has been published in *The Journal*. The viewpoints of the medical profession of Ohio have been communicated to the members of Congress from this state.

However, we would be remiss if we did not voice the warning that the fight on the issue of Federal or state compulsory sickness insurance has just started.

It is true that the Federal Social Security Act, as finally amended, makes no reference to health insurance. Legislation proposing compulsory state health insurance has not been enacted in any state, although such proposals were introduced in six or seven states during the past year.

Nevertheless, this does not mean that the greatest crisis to confront the medical profession in this country has passed.

Those who are determined to secure the enactment of compulsory health insurance are neither satisfied nor discouraged. They will continue their campaign of propaganda and pressure. During the next few years, the medical profession must concentrate on public relations and put up a more vigorous fight than ever before to prevent pernicious legislation of this type.

No one should be optimistic enough to believe that sickness insurance is not an issue of national importance. The same may be said with respect to the question of state health insurance which becomes an increasing menace due to the decision of the Federal Government to postpone action on Federal legislation.

Problems relating to medical care for the indigent and the numerous difficulties which medical organization has encountered in trying to secure adequate compensation for physicians attending the poor and maintain the quality of the services rendered have been handled by the Committee on Public Policy and are adequately covered in the annual report of that committee.

WORKMEN'S COMPENSATION DEVELOPMENTS

Through Dr. B. J. Hein, Toledo, appointed as a special member of the Committe on Medical Economics to keep in touch with workmen's compensation developments of interest to the medical profession, the committee has had an opportunity to assist the State Industrial Commission on frequent occasions and act as an intermediary for the medical profession on workmen's compensation problems.

Frequently during the past year, informal conferences have been held with officials of the State Industrial Commission and the viewpoints of the medical profession submitted to them. Recommendations for improvements in the administrative set-up have been made. Every effort has been made to maintain the cordial and cooperative relationship which has existed between the Commission and medical organization in Ohio.

Acting on the suggestion of Dr. Hein and this committee, the Council of the State Association recently officially requested the Commission to rescind its action of two and one-half years ago imposing a 20% reduction on medical and surgical fee bills. The Commission has the request under consideration and has promised a definite decision on the matter in the near future.

The Committee on Medical Economics cooperated with representatives of the Sherrill Government Survey Commission engaged in a study of the State Industrial Commission and at the request of the Sherrill Commission supplied it with material on medical phases of the workmen's compensation system which has been assembled over a period of years by this and previous committees, together with copies of reports and recommendations heretofore presented to the Industrial Commission and previous investigating groups.

We cannot over-emphasize the importance of the maintenance of an active interest on the part of the medical profession in the field of workmen's compensation and the dangers of unnecessary or ill-advised changes in the Workmen's Compensation Law or administrative procedure.

PHYSICIAN-TO-PUBLIC CONTACTS

To re-emphasize the points stressed at the outset, physicians must inform themselves on these serious issues and make known their viewpoints to the public and in turn learn the viewpoints of cross-sections of the laity.

Effective physician-to-public contact must be maintained. The public must not be left to depend on lay writers and social propagandists for information on the medical aspects of social and economic questions. Physicians must take a more active interest in governmental and legislative affairs since the economic and social problems for which solutions are being sought through legislative enactments and governmental action have a direct bearing on medical practice.

Every physician must realize that public opinion makes and unmakes laws and that the responsibility for molding public opinion on medical questions rests on the shoulders of the medical profession.

In conclusion, the committee takes the opportunity to call the attention of the membership

to the fact that a few men cannot carry the load of putting into effect the suggestions we have offered, and should not be expected to do so.

The economics or public relations committee of a county medical society, or the State Association, can do much but it should not be expected to assume full responsibility for educating the laity and the profession on medical economics. Every physician must do his part and there must be coordinated action to insure the results hoped for. The public is seeking information and leadership from the medical profession. Members of organized medicine must not muff this opportunity.

ANNUAL REPORT OF THE COMMITTEE ON MEDICAL DEFENSE

J. E. TUCKERMAN, Chairman, (1937)....Cleveland
F. P. ANZINGER, (1935).....Springfield
W. H. SNYDER, (1936).....Toledo
CHARLES S. NELSON, Secretary.....Columbus

SINCE its institution in 1916 the purpose of medical defense consistently has been to prevent unjust suits alleging malpractice and to assist the defense of members when so sued.

In general, where civil suits are concerned the question of damage involves controversial matters which may with propriety be adjudicated through compromise. The practice of attorneys to seek compromise in most such suits is to be commended.

But, unfortunately, suits alleging malpractice involve matters that cannot be thus adjusted. A physician either is or is not guilty of malpractice. There is no half-way ground which may be determined by compromise.

Moreover, practically all such suits (as borne out by the experience of your committee) are unjust and entirely unwarranted. The question here is not one of property damage, but is primarily an attack upon professional integrity and reputation.

It is for this reason that your committee has constantly condemned the settlement of malpractice suits by the payment of nominal sums. Settlements so made (on nuisance values) only encourage more such suits and are bad for the physician, the profession and (mark you) in the long run for the insuring companies.

PRINCIPAL CASES SUMMARIZED

It is to be regretted that there are still in the profession those who thoughtlessly criticize or disparage the previous treatment a patient may have received. It cannot be too often repeated that it is always unwise to question in the presence of patients, their relatives or others, the professional standing or ability of a fellow-physician. Such remarks are often misunderstood and occasion dissatisfaction and all too frequently the instigation of suits.

Ill-advised, unjustifiable or loose talk by some physician is one of the most serious and primary causes of suits for alleged malpractice, records of the Committee on Medical Defense show.

These data reveal the following additional causes of suits and threats:

Hope by dissatisfied patient and his attorney to profit.

Desire to injure the defendant's professional standing.

Criticism of physician by relatives or friends of patient.

Carelessness or negligence on the part of the physician; superficial examination and service.

Failure on the part of the physician to keep adequate and accurate records.

Negligence on the part of assistants and attendants employed by physician.

Failure on the part of the patient or his family to carry out the physician's instructions and advice.

STATISTICS ON SUITS AND THREATS

There have been referred to your committee from 1916 to August 1, 1935, inclusive, the following number of suits and threats of suits:

	Suits	*Threats*
1916-1926, inclusive	141	110
1927	10	9
1928	21	7
1929	23	16
1930	16	17
1931	19	20
1932	13	18
1933	23	3
1934	13	7
1935 (January to August)	8	4

These are by no means all the suits filed or threats made against our members during these years There are cases which are not brought to our attention. It would be well if every member when sued or threatened would report to the committee, even though he has an indemnity policy. It should be understood that the defense plan is not, and should not be considered, insurance, as this term is applied to indemnity; nor does it permit the State Association to pay court judgments in any case.

ORGANIZED ASSISTANCE PROVIDED

Designed to prevent the filing of suits and to eliminate the causes of suits, it provides the machinery for organized assistance in event of suits. The committee can aid in the preparation of defense; securing corroborative testimony; and giving advice and suggestions gained from ex-

perience in like cases; can participate in any suit when principles of law affecting malpractice actions are at stake, or where an adverse decision would establish a legal precedent involving the interest of the entire profession; and will intercede in behalf of a physician in case of any difficulties between him and the insuring company.

For prevention, protection and unity of action, as well as advice and assistance, the medical defense plan is of definite value to all members and would continue to be even if every member carried indemnity insurance.

Physicians who carry indemnity should deal only with companies with sound financial rating; should be sure the policy covers the desired protection; and that the contract does not contain technical loop-holes. The physician has a right to know and should insist that his policy protect him against all claims arising from his professional activities.

WHAT TO DO IF SUED

When sued or threatened, the physician should notify at once the executive secretary, Ohio State Medical Association, 1005 Hartman Theatre Building, Columbus, Ohio; fill out according to directions the blanks received from him, and return one completed blank to him and the second completed blank to the chairman of this committee, 733 Osborn Building, Cleveland.

Every member should know the rules and regulations of the medical defense plan.

MUST MEET FOLLOWING REQUIREMENTS

The State Association is barred from aid in the defense of a physician if:

1. He is not in good standing (dues fully paid) in his county medical society and therefore not in good standing in the State Association.
2. The alleged cause of the suit occurred or the suit was filed during a period for which the member is or was in arrears with his dues, or in case the alleged cause occurred previous to the defendant's membership in the State Association. (Annual dues in the State Association are always due in advance on or before January 1).
3. He has failed to forward a medical defense application, properly filled out, to the State Association offices within 10 days after the service of summons.
4. He does not take, or have taken, and keep on file, or have available, *X*-ray pictures of fracture cases, unless it can be shown that at the time and place it was impossible to secure an *X*-ray plate.
5. He has been sued on "cross complaint", having filed a suit himself to collect a bill within one year of the termination of his services.
6. He is believed guilty, after careful investigation, of illegitimate professional actions or service.

LEGAL LIABILITY ANALYZED

Every physician should understand his legal liability and obligations when he undertakes to care for a patient.

Some of the fundamental principles of law and medicine are summarized in the following paragraph:

Legally, a physician is not required to take a case unless he so desires. If he accepts the employment, he contracts to bring to it the average degree of skill, care and diligence exercised by the members of his profession in the same and similar locations or localities, in the light of the present state of medical science. He cannot abandon the case without proper notice to the patient. He must follow the approved methods of treatment, and if there be more than one approved method, he must use his best judgment in determining which method to follow. He must give the patient proper instruction as to the care, attention and caution to be exercised by the patient in his absence. He must attend with sufficient frequency and it is for the physician to determine when no further attention is required. He must use care in the selection of his assistants, or of another to perform an operation which may be necessary. He is liable for the acts of his assistants or for another employed by him, so long as they are jointly engaged, and is liable for the acts of his assistant or intern acting under his direction. Only persons thoroughly competent by reason of education and experience should be employed by him to assist him in the care of patients.

When a physician is eligible to defense under the medical defense plan, the designation of local counsel is entirely in the hands of the counsel for the committee and no contribution will be made to the expense for legal services unless the attorneys are approved by them.

Indemnity companies should be made to realize that they are expected to protect the reputation and professional standing of a physician holding an indemnity policy, not just meet judgments or make settlements.

While a physician's first obligation is to the health (physical and mental) of his patient, nonethe-less he has a very definite obligation to his professional fellows and it is no part of his obligation to a patient to further by word or action the instigation or prosecution of suits for malpractice. And if, through necessity, involved in such a controversy, a physician should, when subpoenaed, present his honest and scientific opinion to the court. On the contrary, hiring-out to designing attorneys and disgruntled patients is, to say the least, not a very dignified procedure for any self-respecting physician. Medical testimony of this kind should be made so difficult to obtain that the instigation of malpractice suits, either for revenge or profit, would cease.

Above all, remember—"A loose tongue inviteth trouble".

ANNUAL REPORT OF THE PUBLICATION COMMITTEE

ANDREWS ROGERS, Chairman (1937).....Columbus
GILBERT MICKLETHWAITE, (1935).....Portsmouth
A. B. DENISON, (1936).....Cleveland

AT no time in the history of organized medicine has there been a greater need for the proper dissemination of timely and accurate information on all phases of scientific medicine and medical practice.

Realizing this, the Publication Committee is deeply cognizant of the important responsibilities entrusted to it in connection with editing and supervising the publication of *The Ohio State Medical Journal*, the official publication of The Ohio State Medical Association and the mouthpiece of organized medicine in Ohio.

It has been the constant aim of this committee through *The Journal* to keep the membership of the Association informed of progress in the field of scientific medicine and of the new ways of applying scientific facts to the prevention and cure of disease.

We have consistently endeavored to keep readers of *The Journal* properly informed on social, economic and governmental developments and trends affecting medical practice and physicians as individuals.

Last Spring, acting upon the suggestion of The Council (that met with the wholehearted approval of this committee), provision was made by the committee to expand the scientific section of *The Journal*. During the past six months greater prominence has been given to scientific presentations and a greater number of scientific papers have been published.

The majority of the papers published in *The Journal* have been presented before the scientific sections at the last Annual Meeting of the State Association, although an unusually large number of submitted manuscripts have been carried.

Following its established policy, the committee has accepted for publication only original articles of scientific value and literary merit which have not been published in contemporary journals. Likewise, we have restricted the columns of *The Journal* to members of the Ohio State Medical Association for obvious reasons, unless the authors reside outside the state.

Although space in *The Journal* is relatively limited and preference must be given to meritorious addresses delivered as a part of the scientific program presented at the Annual Meeting of the State Association, the Publication Committee welcomes voluntary contributions by the members. Some of the most interesting and valuable articles carried in *The Journal* have been of this character; especially is this true of the reports of interesting and unusual cases.

The Journal is the members' journal and we want them all to feel that they have the right to contribute to it. However, it must be kept in mind that unless all the articles maintain the high scientific and literary requirement established by *The Journal*, its influence and value must inevitably decline. A system of careful and double editing is employed by us in an effort to keep the standards of *The Journal* high and the material presented of general interest and definite scientific value.

A study of the carefully-prepared essays published in *The Journal* affords an opportunity for professional development essential to the physician. He must keep abreast of discoveries resulting from medical research and practical experience in handling patients if he is to "grow" professionally.

In furtherance of these ideas, your committee is planning additional improvements in *The Journal*. We hope to develop a department devoted to case histories. Arrangements have been made for the presentation of a series of historical sketches on medicine in Ohio. Thought is being given to the establishment of a book review department. Changes have been made in the make-up of *The Journal* during the past few months. Additional changes will be made from time to time to improve the appearance of *The Journal* and attract reader-interest.

A special effort has been made by the Publication Committee to make the news columns of *The Journal* a potent factor in the activities of the State Association. The physician today must be familiar with social, economic and governmental questions. Many paternalistic and socialistic programs in which medical service is directly involved have been launched in many parts of the country. These must have the careful scrutiny of the medical profession in order that physicians may base their opinions on accurate data.

For that reason, we have carried in *The Journal* explanatory articles on some of the most talked-of experiments in the field of medical economics. Some of these have been republished from other journals; others have been formulated by our State Headquarters Office from data secured from authentic sources. *The Journal* will continue to publish news concerning innovations bearing on the social and economic aspects of medical practice and when appropriate will endeavor to interpret them in the light of the fundamental policies of the State Association.

As customary, *The Journal* has published during the past year many articles dealing with legal matters and court opinions of interest to the profession; changes in governmental regulations and statutes; actions of the Ohio General Assembly and the U. S. Congress; activities of

hospitals and activities in the fields of public health and welfare. In addition, the work of The Council, its officers and the various committees of the State Association has been reported from time to time.

Through the cooperation of many of the secretaries of the component county medical societies and academies of medicine, and individual members, *The Journal* has been able to publish an unusual amount of interesting news relative to physicians in all parts of the state and a comprehensive month-by-month report of the official activities of the various county societies and academies. However, there still is need of better cooperation on the part of some county society secretaries or correspondents in the matter of furnishing local news and accounts of county society meetings. Incidentally, all news submitted to *The Journal* should be received by the State Headquarters Office not later than the 12th of the month preceding the date of publication of *The Journal*, which is the first of each month.

We are gratified to report an increase in the amount of advertising carried in *The Journal*. We have continued to maintain a strict censorship over all advertising copy submitted for publication. It must have the approval of this committee, the Cooperative Medical Advertising Bureau of the American Medical Association and the A. M. A. Council on Pharmacy and Chemistry. Advertisers who succeed in running the gauntlet protecting the columns of *The Journal* deserve the financial support of the membership.

In conclusion, the Publication Committee has the following requests to make of the members:

1. Preserve your Journals for future reference. Have them bound by volumes. *The Journal* is in effect a detailed and accurate history of the activities of organized medicine in Ohio.

2. Read every issue of *The Journal* carefully. It always contains many articles of interest and value.

3. Send us comments, suggestions and criticisms relative to *The Journal*, as well as contributions. It is *your Journal*. You can be instrumental in improving it. Help us make it an even more important factor in promoting the interests of organized medicine.

ANNUAL REPORT OF THE COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

BEN R. MCCLELLAN, Chairman (1937).....Xenia
R. H. BIRGE (1935).....Cleveland
JOHN F. WRIGHT (1936).....Toledo

THESE are difficult times for those engaged in the practice of medicine. Medicine is the target for theorists and reformers. Physicians have been hit hard financially; many have been forced to struggle to maintain their practice on a basis which will return them an adequate income. Demands on the profession for gratuitous services have been enormous. Proposals involving changes in the distribution of medical care have kept the profession in a confused state of mind.

The natural result has been that physicians are devoting more and more attention to the economic and social aspects of medical practice.

Far be it from this committee to discourage thinking on the part of the profession or discussions at group meetings regarding the economic and social side of the practice of medicine. However, we believe all members should avoid placing so much emphasis on the business side of medical practice that they have little time left for its scientific phases or inclination to give them the consideration they deserve. Medicine is progressive. If we desire—and most physicians do—to become better physicians, we must be alert to the advances taking place almost daily in the field of scientific medicine. We must seek new knowledge and take part in activities which will give to others the benefit of our own clinical experiences.

Dr. Walter L. Bierring, Des Moines, Iowa, retiring president of the American Medical Association, in his address to the A.M.A. House of Delegates this year, made an impressive statement when he said:

"If the medical profession is to maintain its nobility of purpose and obligation to society it can only be by the quality of its service and the qualifications of those rendering this service."

No physician can progress and enhance his qualifications unless he is given an opportunity to learn about new discoveries and new methods, and takes advantage of such opportunities when offered.

POST-GRADUATE ACTIVITIES

This brings us to a point which cannot be overemphasized.

One of the principal functions of medical organization is to see that such opportunities are afforded practicing physicians. In other words to actively promote post-graduate education.

This can be accomplished through county and district medical meetings, clinical conferences, refresher courses in cooperation with medical institutions, etc.

Even in good times it is impossible for many physicians to leave their practice long enough to attend formal post-graduate assemblies. Oppor-

tunities for post-graduate instruction must be made easily accessible to all physicians.

The first step should be taken by the local medical society. Special care should be taken in arranging programs. Subjects and speakers should be selected with discrimination. All members of the society should be given an opportunity to take part in the programs. Of course, speakers of note from other communities should be invited to appear before the society when it can be arranged. A good program committee can convert a "dead" society into an unusually "live" one and can help to improve the quality of the medical service of the community.

District meetings are important. They provide an opportunity for speakers on subjects of particular importance to reach a greater number of practitioners at the same time and for physicians to exchange ideas with a greater number of their colleagues.

The recent action of The Council of the Ohio State Medical Association providing assistance and active cooperation on the part of the State Association with the various district societies is commendable and a step in the right direction. It is hoped the district groups will take advantage of the assistance offered by the State Association, which, we believe, will enable them to present better programs and incidentally stimulate interest on the part of the membership in the activities of the State Association.

SPEAKERS' BUREAU CONSIDERED

It is noted that The Council has under consideration a plan for the organization of a speakers' bureau, the function of which would be to assist county and district societies in securing scientific speakers and serve as a clearing house for post-graduate activities.

We approve of this idea and recommend that The Council inaugurate this service when practicable and feasible.

Ohio's medical schools have undertaken to make available their facilities to physicians desiring to attend refresher courses and clinical demonstrations. They have done a good piece of work. The extension of this post-graduate activity should be encouraged. Definite arrangements should be made for active cooperation between the medical schools and medical organization in promoting this work.

Every physician can improve himself by studying the best of the current medical periodicals. Few physicians can afford to subscribe for all the medical periodicals of interest and value. It is suggested that physicians pool their subscriptions and that possibly through their local medical society, arrange for some central location where a library on a small scale can be established for the benefit of all members. Incidentally, every physician should be a subscriber to *The Journal of the American Medical Association*, the most valuable medical periodical published.

These brief comments on phases of post-graduate activity are presented with the hope that they will stimulate thinking and activity on the part of the membership and will bring forth additional suggestions from individual members as to how the State Association can assist in promoting this most important part of medical education.

OHIO'S MEDICAL SCHOOLS RANK HIGH

The committee wishes to compliment Ohio's three Class A medical schools for their high standards and the ranking they continue to maintain in the field of medical education. The medical profession of Ohio has just reason to be proud of them. Stringent entrance requirements, careful selection of students, competent teachers, and adequate clinical and laboratory facilities have been combined by them to furnish Ohio with physicians properly equipped for active practice.

It is suggested that the medical schools of the state consider the possibility of augmenting the practical training of each student by placing him under the supervision of a man in active practice. This contact could be made during vacation periods and would give the student knowledge of the economic and social relationship of the doctor to his clientele and to the community, as well as valuable clinical experience.

We recommend that the medical colleges of the state place more emphasis on the training of students in the economics of medical practice. It has been stated that some recent graduates are inclined to look upon sickness insurance and other socialized programs as a desirable means of providing them with a sure source of income particularly when they start in practice. Available records from foreign countries where sickness insurance is in effect show this reasoning to be fallacious. We feel that the young graduate should be sufficiently grounded in social and economic questions so that he can get the true picture of plans and proposals for changing the existing system of medical practice.

The following quotation from the annual oration delivered by Dr. S. Bayne-Jones, professor of Bacteriology of the Yale University School of Medicine, before the Louisiana State Medical Society is apropos:

"Aside from considerations of provisions for scientific, technical and clinical training in medical schools, there is great need in these days for the development of a free spirit of inquiry into the numerous schemes for the regulation and so-called socialization of medicine which are now before federal, state and municipal governments. Teachers and students should be at liberty to examine and question these plans without fear of personal loss and without the demoralizing suspicion that advancement may be gained only through concurrence with a party in power, regardless of the wisdom or truth of a policy. Medical education must include an increasing amount of examination and discussion of community, social and governmental problems. Since investigations of these vital and changing questions cannot be undertaken by the student

with the same detachment with which he would inspect a lithopedion, it is necessary that he and his teachers should be free to consider all the implications of the economic and social panacea, sickness insurance plans and medical regulations which will be advanced with the force of authority in this rapidly changing world. Unless this spirit of freedom is maintained in medical teaching, the physician of the future will be a routine servitor of his political and industrial governors."

So that the membership will have a picture of the outstanding position held by Ohio's medical schools and be informed as to their present status, the committee requested the deans of the three schools to furnish it with the following data:

WESTERN RESERVE UNIVERSITY, SCHOOL OF MEDICINE

Western Reserve University School of Medicine assumed its present title in 1881, having been organized as the Cleveland Medical College in 1843. In 1910 the Cleveland College of Physicians and Surgeons was merged. It has been coeducational since 1919. The faculty consists of 63 professors and 163 lecturers, assistants and others, a total of 227. The curriculum covers three years of eight and one-half months and one year of nine months. Graduation from an approved college or scientific school or equivalent, following completion of a course of at least three collegiate years, is required for admission. The total fees for each of the four years are, respectively, $442, $435, $415 and $425.

The 93rd session of the school was opened September 19, 1935, with an enrollment of 264 students, 14 less than were enrolled for the year 1934-35. Following are figures on enrollment and graduates for the past six years:

NUMBER OF STUDENTS

	1935-36	1934-35	1933-34	1932-33	1931-32	1930-31
First year	75	80	81	79	78	75
Second year	67	68	65	74	60	61
Third year	65	60	71	55	62	61
Fourth year	57	70	55	61	58	58
Total	264	278	272	269	258	255

NUMBER OF GRADUATES

1930	54	1933	61
1931	58	1934	53
1932	57	1935	71

While formal entrance requirements have remained unchanged, there is an increasing emphasis on the individual qualifications of the applicants in the selection of first-year students.

The faculty of the school has approved a plan for liberalizing somewhat the curriculum for the first two years. Under the new plan, the basic course of 1728 hours for the first two years is required of all students. Outstanding students, approximately the upper seventh of the class, may use all the remaining time for optional work, taking organized courses or not, as they desire. The rest of the students are required to take organized courses during approximately one-half of the free time, using the remainder in supplementing their studies along the lines of their own volition. Optional supplementary courses are being offered in embryology, nutrition, physiology, and pathology.

The comments of Dr. Torald Sollmann, dean of the school, concerning this new plan are of special interest. He said:

"Theoretically, at least, this plan appears to offer advantages. It preserves a fixed basis curriculum, amounting to approximately three-fourths of the present course, and avoids imposing an excessive number of assigned hours which the average inexperienced student could not be expected to plan advantageously. It is in consonance with the present tendency of other schools to cut down the large blocks of free time in the first two years, with which they have experimented.

"It gives all students some choice of subjects, minimum requirements having been fulfilled.

"It gives the abler students an opportunity to pursue subjects in which they are especially interested, for a sufficient time to make the effort worth while, without prejudice to required work."

Changes in sequence have been made. Biochemistry, formerly taught in the first half year, is transferred to the second half year, putting it in closer relationship with physiology. Physiology will be given in the first half of the second year.

The final examinations in all second year subjects will be given at the end of the second year irrespective of the time of year when the subject ends.

The following faculty changes and promotions were made previous to the opening of the current school year:

Promoted to professor, Dr. Harry Goldblatt, experimental pathology; promoted to associate professors, Dr. Edward Muntwyler, biochemistry; Dr. John P. Quigley, physiology; promoted to associate clinical professor, Dr. John J. Thomas, obstetrics; promoted to assistant professor, Dr. T. T. Zuck, anatomy; promoted to assistant clinical professors, Dr. F. C. Oldenburg, medicine; Dr. Clyde L. Cummer, dermatology and syphilology; Dr. J. W. Holloway, surgery; Dr. Arthur J. Horesh, pediatrics. Dr. Paul Gyorgy has joined the staff as visiting assistant professor of pediatrics.

The following have resigned from the faculty: Dr. Gaius E. Herman, to become chief of the Bureau of Epidemiology, Chicago Board of Health, and professorial lecturer in epidemiology and vital statistics at the University of Chicago; Dr. M. A. Blankenhorn, to become head of the department of internal medicine, and Taylor professor of medicine, University of Cincinnati, School of Medicine.

A special grant of $8500 per year for two years (made in 1934) for the support of experimental pathology has been made jointly by the Beau-

mont Foundation and Messrs. Charles L. and Nathan G. Richman and Richard Kohn.

With the reopening of Maternity Hospital and Babies and Childrens Hospital, the entire University Hospitals group is again made available for teaching purposes.

UNIVERSITY OF CINCINNATI, COLLEGE OF MEDICINE

University of Cincinnati, College of Medicine, was organized in 1909 by the union of the Medical College of Ohio (founded in 1819) with the Miami Medical College (founded in 1852). The Medical College of Ohio became the Medical Department of the University of Cincinnati in 1896. Under a similar arrangement, March 2, 1909, the Miami Medical college also merged into the University, when the title of Ohio-Miami Medical College of the University of Cincinnati was taken. The present title was assumed in 1915. Candidates for admission to the freshman class must present three years of pre-medical work, 90 semester hours, in a college of satisfactory standing. The faculty consists of 117 professors and 196 associates, assistants, etc., a total of 313. The course covers four years of eight months each. A fifth year, during which the student serves an internship at some accredited hospital under the supervision of a member of the faculty, is required before the degree of doctor of medicine is conferred. The total fees for the four years are, respectively, $360, $370, $360 and $380, and if not legal residents of Cincinnati, $50 additional.

The second year of the college under the deanship of Dr. Alfred Friedlander, opened September 23, 1935, with 286 students enrolled, and 68 in internship. Comparison of this year's enrollment and 1935 graduates with those of previous years is as follows:

NUMBER OF STUDENTS

	1935-36	1934-35	1933-34	1932-33	1931-32	1930-31
First year	75	75	91	90	90	90
Second year	70	79	76	77	75	73
Third year	72	72	68	72	75	65
Fourth year	69	69	74	74	67	61
Fifth year (internship)	68	73	72	67	59	57
Special	—	—	9	3	5	—
Total	354	368	390	383	371	346

NUMBER OF GRADUATES

1930	58	1933	67
1931	61	1934	71
1932	60	1935	73

The freshman class is annually limited to 75 students, and there are about eight applicants for each available place.

Preference is given to students who have received an academic degree, and next, to those students who are eligible for an academic degree after the completion of their first year in medicine. In addition to specified requirements much weight is attached to letters of recommendation regarding the individual students from the science instructors in the college of liberal arts attended. In the case of the University of Cincinnati and Xavier University, Cincinnati, group opinions are handed to the Admissions Committee and have considerable weight. Considerable importance is attached to the performance of the students in the medical aptitude tests.

Some changes have been made in the curriculum. A course in geriatrics at the Chronic Disease Hospital will be amplified this year. This is an elective course for seniors, limited to 20 men chosen from the upper half of the class. The same will apply to the course in anaesthesia to be given this year.

The Department of Radiology will expand its work, so that during the first year there will be demonstrations in radiologic anatomy; in the second year in radiologic physiology and in the junior year in radiologic pathology. The course in military medicine will be expanded to include lectures on aviation medicine.

Dr. David A. Tucker, Jr., professor in the history of medicine, will expand his course on the history of medicine, which is elective for seniors..

Dr. Marion A. Blankenhorn, formerly professor of clinical medicine, Western Reserve University, School of Medicine, became Helen and Gordon Taylor professor of internal medicine and head of the department of medicine, University of Cincinnati, September 1, 1935. Dr. T. A. Spies, Dr. Blankenhorn's associate at Cleveland, accompanied him to Cincinnati, where he is assistant professor of research medicine.

Dr. Mark P. Schultz, who has been at the Rockefeller Institute for six years, became research fellow in pediatrics and internal medicine, September 1. He will devote himself to the study of rheumatic fever and arthritis. An assistant professor of pharmacology will be appointed to succeed Dr. John H. Foulger, resigned.

OHIO STATE UNIVERSITY, COLLEGE OF MEDICINE

Ohio State University, College of Medicine, was organized in 1907 as the Starling-Ohio Medical College by the Union of Starling Medical College (organized in 1847 by charter granted by the state legislature changing the name from Willoughby Medical College, which was chartered March 3, 1834) with the Ohio Medical University (organized 1890). In 1914 it became an integral part of Ohio State University, with its present title. The faculty includes 49 professors and assistant professors, 66 lecturers, demonstrators and others, a total of 115. Three years of collegiate work is required for admission. The course covers four years of 34 weeks each. Tuition fees are $246, $231, $231, and $241 each year, respectively, for residents of Ohio, and $150 additional for nonresidents.

The next session of the college, opening October 1, 1935, had an enrollment of 100 freshmen,

89 sophomores, 92 juniors and 88 seniors, according to Dr. J. H. J. Upham, dean of the college.

The enrollment and number of graduates for the past five years were:

NUMBER OF STUDENTS

	1934-35	1933-34	1932-33	1931-32	1930-31
Freshman	101	101	101	100	100
Sophomore	97	90	85	86	80
Junior	89	85	88	92	70
Senior	90	89	90	76	79
Total	377	365	364	354	329

NUMBER OF GRADUATES

1930	58	1933	88
1931	78	1934	86
1932	75	1935	83

The number of applicants seeking admission continues to be in excess of the facilities of the college. Therefore the number of first year students admitted remains at 100. In fact the large classes in the clinical years strain the clinical teaching facilities to the limit and may force consideration of reducing the number in the first-year class.

The Entrance Board has a difficult task in making selections. However, the care shown is reflected in the steadily decreasing number of failures. In addition to the formal requirements, all applicants are given personal interviews, and considerable importance is attached to their scholastic standing, personal character, aptitude and general intelligence.

There have been some minor changes in the curriculum to better correlate the pre-clinical instruction with the clinical, and provide earlier and more bedside contact with patients.

Certain additions to the faculty are contemplated, but no announcement can be made at this time because of the uncertainties of the University's budget allotment.

HOSPITAL PROBLEMS STUDIED

The committee has studied some of the problems confronting the hospitals of Ohio, most of whom are confronted with financial difficulties due to prevailing economic conditions.

The medical profession should assist hospitals in demanding that public funds be made available for the hospitalization of the poor requiring such service. At the same time hospital officials should cooperate with the medical profession in securing for physicians fair compensation for their services to indigents.

Physicians can assist hospital authorities by aiding them in keeping operating costs at a minimum. Of course, hospital boards should permit the medical profession to have a voice in administrative matters, especially those bearing on the scientific activities of the institution.

The building of new hospitals or the enlargement of present ones should be discouraged unless a definite need for increased hospital facilities has been proved. Expansion should give way to an effort to reduce capital indebtedness.

A splendid opportunity for teamwork between physicians and hospital authorities lies in the training of interns. Occasionally this important feature of medical education is neglected by hospital officials and members of the medical staff.

This committee has cooperated with The Council on Medical Education and Hospitals of the American Medical Association and takes this opportunity to highly commend the council on the indispensable work it is doing.

Through the cooperative efforts of officers of the State Medical Association and the officers of the Ohio Hospital Association, a better understanding of mutual problems has taken place. We trust that this relationship will continue.

In conclusion, we present interesting data on hospitals throughout the nation and those in Ohio, believing members of the medical profession should have an opportunity to inform themselves on the status of this allied group.

NATIONAL STATISTICS PRESENTED

During the calendar year 1934, according to the fourteenth annual presentation of hospital data by the Council on Medical Education and Hospitals of the American Medical Association, (March 30, 1935, issue *The Journal of the American Medical Association*) there were 6,334 registered and approved hospitals in the United States, as compared with 6,437 in 1933, a net decrease of 103 hospitals. This decrease was caused, in part, by thirty-one custodial institutions closing their hospital departments and sending their patients to neighboring general hospitals. Thirty-nine general hospitals were closed or service temporarily discontinued because of lack of patronage. Forty hospitals were dropped from the approved list for ethical reasons, as against 21 restored from those formerly rejected.

During 1934, the capacity of approved hospitals was 1,048,101 beds and 53,026 bassinets, with a total of 7,141,416 patients admitted, an average daily census of 830,098 and a total of 302,985,770 patient days. The total number of births reported in hospitals was 701,143, of which 48,048 were in maternity hospitals. According to the estimated census for 1934, one person in eighteen made use of a hospital during the year. The average length of stay per patient in general hospitals was 14 days.

Hospitals in the United States employ 6,105 laboratory technicians and 4,300 *X-ray* technicians. There are 2,226 superintendents who hold the M.D. degree, 2,551 are registered nurses, and 1,545 are without medical or nursing degrees.

Of the 6,334 approved hospitals, 4,271 or 67.43% have clinical laboratories; 4,488 or 70.86% have their own radiology departments; 2,008 or 31.7% have physical therapy departments.

Hospitals totaling 2,319 have outpatient departments and in 1934 served 9,885,465 patients who made 34,358,606 visits.

Hospitals approved for internship offered 6,204 internships and 2,373 residencies.

FIGURES ON OHIO HOSPITALS

Ohio maintained its high ranking in the hospital field during 1934. Hospitals in Ohio approved by the Council on Medical Education and Hospitals of the American Medical Association

numbered 264, with a capacity of 51,294 beds and 2,515 bassinets, 155 of these were general hospitals with an average bed occupancy of 60.8%. Patients admitted were 317,680, and the average daily census was 41,631. Ohio hospitals totaling 191 had clinical laboratories in 1934; 183 had *X*-ray departments; 83 had outpatient departments, serving in 1934, 362,910 outpatients who made 1,487,473 visits.

The following Ohio hospitals, numbering 37, have been approved for intern training: City Hospital, Akron; Peoples Hospital, Akron; St. Thomas Hospital, Akron; Mercy Hospital, Canton; Bethesda Hospital, Cincinnati; Christ Hospital, Cincinnati; Cincinnati General Hospital; Deaconess Hospital, Cincinnati; Good Samaritan Hospital, Cincinnati; Jewish Hospital, Cincinnati; St. Mary Hospital, Cincinnati; Charity Hospital, Cleveland; City Hospital, Cleveland; Huron Road Hospital, Cleveland; Mt. Sinai Hospital, Cleveland; St. Alexis Hospital, Cleveland; St. John's Hospital, Cleveland; St. Luke's Hospital, Cleveland; University Hospitals, Cleveland; Woman's Hospital, Cleveland; Grant Hospital, Columbus; Mt. Carmel Hospital, Columbus; St. Francis Hospital, Columbus; Starling-Loving University Hospital, Columbus; White Cross Hospital, Columbus; Miami Valley Hospital, Dayton; St. Elizabeth Hospital, Dayton; Elyria Memorial Hospital, Elyria; Mercy Hospital, Hamilton; Springfield City Hospital, Springfield; Flower Hospital, Toledo; Lucas County General Hospital, Toledo; Mercy Hospital, Toledo; St. Vincent's Hospital, Toledo; Toledo Hospital; St. Elizabeth's Hospital, Youngstown; Youngstown Hospital.

Ohio hospitals approved for residencies in specialties number 26. They are: Children's Hospital, Akron; City Hospital, Akron; St. Thomas Hospital, Akron; Children's Hospital, Cincinnati; Cincinnati General Hospital; Cincinnati Sanitarium; Good Samaritan Hospital, Cincinnati; Jewish Hospital, Cincinnati; Charity Hospital, Cleveland; City Hospital, Cleveland; Cleveland State Hospital; Mt. Sinai Hospital, Cleveland; St. Alexis Hospital, Cleveland; St. Ann's Maternity Hospital, Cleveland; St. John's Hospital, Cleveland; St. Luke's Hospital, Cleveland; University Hospitals, Cleveland; Childrens Hospital, Columbus; Columbus State Hospital; Starling-Loving University Hospital, Columbus; Dayton State Hospital; Miami Valley Hospital, Dayton; Ohio State Sanatorium, Mt. Vernon; Women's and Children's Hospital, Toledo; Cleveland Tuberculosis Sanatorium, Warrensville; Youngstown Hospital, Youngstown.

ANNUAL REPORT OF SPECIAL COMMITTEE ON PREVENTIVE MEDICINE AND PERIODIC HEALTH EXAMINATIONS

V. C. ROWLAND, Chairman.....Cleveland
C. W. BURHANS.....Lakewood
JONATHAN FORMAN.....Columbus
BEATRICE T. HAGEN.....Zanesville
R. R. HENDERSHOTT.....Tiffin
A. J. SKEEL.....Cleveland
C. I. STEPHEN.....Ansonia

THE objective of the Committee on Preventive Medicine and Periodic Health Examinations is to promote the cause of preventive medicine in all its forms but especially in those phases in which the personal participation of the individual is required. Public sanitation is largely impersonal and at present is thoroughly established. There remain many phases of public health activities which must be closely correlated with personal preventive medicine and developed with the cooperation of all parties concerned.

As in most progressive movements some new ideas and broader viewpoints have emerged from the activities and experiences of the committee. The first of these is a slight change in technique or rather a shifting of emphasis from the active campaign for the popularization of preventive health examinations among the laity to a slow continuous education by the family physician among his own clientele. There has in fact been a great deal of indefiniteness about what a health examination really is. Overemphasis upon a routine physical examination without consideration of personal hygiene and potential disease has tended to ritualize the procedure and diminish its usefulness. Our committee has for several years emphasized the limitations of a purely perfunctory physical examination. The New York Academy of Medicine has abandoned its high-powered campaign and settled down to a slow continuous process of education through its monthly publication *"The Health Examiner"*, and by cooperation with medical school faculties in both undergraduate and postgraduate teaching.

A stereotyped physical examination without any attention to clinical leads may be done in ten or fifteen minutes and in itself is well worth this amount of time. The examination, however, is but an entering wedge to a complete health inventory and survey of preventive possibilities. The intelligent approach is by mature clinical appreciation of the hereditary background, individual type, personal history, emotional attitude, habits, the probabilities of vital statistics, etc. With this approach, just as in diagnostic practice, attention is concentrated in the examination on the probable sites of disease. Results then fully warrant the effort.

Many of the most valuable preventive opportunities, however, are presented when the physical examination is entirely negative. Especially in the more intelligent classes functional disorders are becoming increasingly frequent. Physical examination alone would just be the starting point in order to exclude signs of organic disease. Then

all the native and educational resources of the physician may be brought into play to work out the exact situation and to influence the patient to correct the disturbing factors. Certainly this is highly individualized service of a type that can never be mechanized or provided by an impersonal type of medical practice. In fact only the mature clinician appreciates fully what these personal relationships mean.

Privacy is also essential in a preventive health interview even more than in illness, because the whole psychology of the situation tends towards levity in the presence of a group. No red-blooded man wants to betray an introspective tendency or concern about his own health. Good fellowship shows quite the opposite attitude. Hence group demonstrations on laymen or physicians have never been popular. The proper setting is provided when the patient asks for an examination because his friend or a member of his family has just died unexpectedly or of a preventive disease. Such a patient wants privacy. Sound optimism and encouragement can be provided on such an occasion as well as common sense prevention. Neuroses can be prevented by tact and a genuine personal interest.

What is needed is the ideal of preventive medicine which can be brought to bear all through private practice. This seems simple in principle but in practice means the changing of established habits and viewpoints. The older practitioner engrossed with the care of sick people is apt to have little patience with what seems to be pampering those who are only potentially sick or in the functional stage of disease. When we consider that nearly as many beds are occupied for nervous and mental disease as for all other diseases combined, namely, about one million of each, and in a great percentage of such cases physical examinations are negative it becomes very apparent that if anything is to be done aside from eugenic methods and sterilization of the unfit it must be done in the very early preclinical stage by the control of personal hygiene and the avoidance of those factors which bring out functional and mental disorders.

COOPERATION WITH HEALTH OFFICIALS

The second observation of the committee is a very definite trend toward increased cooperation between public health officials and the organized medical profession. The old antagonism seems to be passing not only because there is better mutual understanding but because further progress in public health necessarily requires the personal cooperation of the individual. The great depression also aided by lack of funds in shifting much medical work back to the private practitioner where it properly belongs. There seems to be a more general willingness to accept what the medical profession has long maintained that the expansion of public health services should be limited to the educational and preventive fields.

As an example of the newer attitude the May 1935 *Bulletin* of the American Medical Association urges the diphtheria immunization as an "excellent opportunity for constructive cooperation between the medical profession, state and local public health offifficials and voluntary health organization interested in child health".

There need not be great concern about the laity and their grasp of the general idea of preventive medicine since they are now getting such suggestions through many channels. One million students between the ages of 17 and 24 are in attendance at high schools and colleges. Instruction in hygiene and preventive medicine is playing an increasing role in lay education. Such leaders as Dr. Harry Overstreet are placing the study of the human body in first place in the essentials of the educational system of the future. Ninety thousand graduates each year are entering society as leaders expecting preventive health services from the profession. The important concern of the profession is to provide the proper individualized service to really get results.

PROBLEMS IN INDUSTRIAL MEDICINE

The committee notes further that industrial medicine is presenting an increasing field for preventive medicine and with proper technique an opportunity to cooperate with rather than compete with the private practitioner. Occupational disease is definitely on the increase. Many states are now considering new compensation laws. At least six states are considering the establishment of a Bureau of Industrial Hygiene in their state health departments. This possibility was brought to the attention of those interested in revamping the Ohio Department of Health. Such a bureau would be designed to prevent industrial disease at the source rather than compensate for its results. The bureau would be investigative not punitive and its method would be largely educational. There are at least four groups involved in such activities, namely: the employers, the employes including the labor unions, the insurance companies, and the physicians, all of whom lose by the occurrence of industrial disease. There have been, however, frequent clashes between these groups due to improper methods. It has been shown that employers will welcome investigation and constructive suggestions if they are assured that information given is confidential. To meet this requirement it is proposed to have all findings of the industrial bureau exempt under the law from subpoena in litigation. Connecticut has such a system at present. Labor unions who at first resisted such investigations not only welcome them when they realize that workers are not displaced by industrial investigations but even report industrial

hazards to the bureau. Insurance companies, of course, welcome any reduction of hazards. Finally after environmental conditions are reported upon health examinations are recommended but to be carried out by the private physician. In this way the cost of such an industrial bureau is not excessive and all parties concerned are benefited. At present there is an actual lack of personnel to meet the requirements of industrial firms to carry out expert investigation of industrial hazards. It is said that there are at present 900 hazardous occupations employing 15,000,000 workers in the United States.

The committee believes that the Ohio State Medical Association should encourage the movement to re-establish the Department of Industrial Hygiene and Preventive Medicine in our own State Department of Health.

PREVENTIVE MEDICINE AND OBSTETRICS

Another division of medicine in which personal preventive medicine is combined with semi-public health measures is in obstetrics. Prenatal instruction still lags and obstetrical mortality and morbidity rates are higher than they should be. The National Committee on Maternal Welfare is cooperating with the American Hospital Association in establishing standards. Their State Committee is represented by Dr. Skeel, a member of the Committee on Preventive Medicine and Periodic Health Examinations of the Ohio State Medical Association.

The main object of this movement at present is to secure adequate prenatal care. The plan initiated last year of publishing, under the auspices of the State Department of Health, articles on the importance of prenatal care in the county newspapers of the state will be carried out more fully this year. The county medical societies should cooperate with the county health authorities to see that such publicity is carried out. In addition, radio publicity and talks such as requested by women's clubs may be provided for by the local medical society or in the event that no suitable speaker is available, through this committee.

MATERNITY AND INFANCY PROGRAM

The committee has been intensely interested in the contemplated activities in Ohio as a part of the program in maternity and infancy education to be financed from the funds of the Federal Social Security Act.

We have carried on several unofficial conferences on this matter with officials of the State Department of Health and have been assured that medical organization will be called upon for cooperation, assistance and advice on the conduct of this program in Ohio.

It is anticipated that such a program will be solely educational in character with the possible exception of providing bedside nursing care in rural communities where such care is sorely needed. It is important that the profession cooperate and direct the proper use of the new government money available for health purposes. Such cases would be under the care of the private practitioner and provide further example of the way in which private preventive medicine will be practiced in the future.

IMMUNIZATION AND SCHOOL INSPECTIONS

Pediatrics likewise has its American Academy of Pediatrics with its state committees. In Ohio they are represented by Dr. Burhans, a member of the Committee on Preventive Medicine and Periodic Health Examinations. They are at present most concerned with the popularizing of diphtheria immunization especially in the smaller communities, a need which has been emphasized by the whole of organized medicine. It is desirable that these procedures be carried out as far as possible by the private physician but it must be remembered that the public health authorities have the legal obligation of protecting society if such service is not provided privately.

In order to determine the percentage of children now immunized against diphtheria the Division of Health of Cleveland examined 4,000 children as a sample of the general child population. Only about 20 per cent of children under one year of age had been protected; 40 per cent between the ages of two and five; and 66 per cent between six and fourteen years. This indicates that practically two-thirds of the child population under six is still not protected against diphtheria. An educational campaign was then started on a large scale to immunize the preschool group. The Cleveland Health Council, a lay agency, carried out the public propaganda and the Academy of Medicine cooperated by providing a list of physicians who agreed to give the toxoid at a nominal charge to children under seven years of age. Such methods must be used more widely around the state if diphtheria is to be really eliminated. No intrusion into private practice will be necessary if the practitioner will only learn to immunize his children during the first year.

School inspection services are under present conditions a definite part of the preventive medical program and must be supported by the physician in whatever degree they are not provided for by the private practitioner. For example, so long as children do not have health examinations including eye examinations they will never have early correction for refractive errors. As stated in the Ophthalmological Section at the recent meeting of the American Medical Association, an early correction of myopia prevents progressive increase in the refractive error. Consequently

any system that provides for this service in children justifies itself. The committee believes that this service can always be better provided privately but must insist that the school inspection and similar services be encouraged so long as they are not otherwise provided for by private practitioners. The same applies to teeth, tonsils and other defects.

There is evidence that the pre-school group of children have suffered more than any other age group for lack of health service. This is a group that has lost out between the infant clinics and school health services. The private practitioner should concentrate upon this age group or expect to see an extension of the infant welfare program upwards and an extension of the school program downwards in order to reach the pre-school group for the necessary immunizing and preventive services. Already there have come into existence special centers such as day nurseries, nursery school and pre-school health and recreation centers to meet this need. At present, however, only about one child in fifty has been contacted—just enough to provide an educational demonstration. This is a fertile field for the private pediatrician and family physician providing a preventive opportunity in the period of life where it counts for the most. Also in this period preventive health measures require a considerable degree of parent education which can best be provided by the family physician. The relatively small number of pre-school children in institutions are well provided for in health matters. It should be the duty of the family physician to see that the child in the home is no less fortunate.

EDUCATION OF PHYSICIANS THEMSELVES

The pediatricians are also much interested in extending preventive pediatrics among general practitioners by holding meetings and round table conferences at county society meetings and especially district meetings. This plan has worked out very satisfactorily in other states. The Committee on Preventive Medicine and Periodic Health Examinations believes they can be more effectively carried out during this next year. The committee will also be privileged to cooperate with the State Department of Health in health educational publicity. Dr. A. L. Van Horn of that department is especially interested in this work.

In the general medical field there is greatest opportunity for preventive health service if only doctors and patients are wise enough to take advantage of it. The above group of activities in certain special fields of medicine in which semi-public services are correlated with personal preventive medicine should serve to show the way. The much larger field is that of private practice. One must have the vision to look ahead in health rather than backward in disease. Experience has shown that it is essential that the viewpoint of preventive medicine be inculcated early in the medical student at the beginning of his clinical work.

There has been a fixed habit of starting medical studies with advanced pathology as seen at the postmortem table and the symptoms of advanced clinical disease. Some teaching of this kind is, of course, essential. However, the farther back investigation goes from this end stage to the incipient and preclinical stages the less interest has been shown. From the human standpoint the exact opposite needs to be done. Emphasis is to be placed upon etiological factors and their control. Psychologically one can understand that this phase of medicine would appeal more to the mature student. A little questioning of internes of a large hospital, coming from different medical schools will promptly reveal that the teaching of preventive medicine, public or personal, has not been the most popular department as a rule. This is partly because it has been so impersonal and so detached from clinical practice, "A mass of statistics", as one recent graduate expressed it, and mostly unsympathetic with the private practitioner. This aloofness should be overcome. The idea is to infuse the preventive viewpoint all through clinical teaching so that it becomes part and parcel of the clinical thinking of the student. In this way personal preventive medicine can be made to appeal increasingly to the future practitioner. Improvement is coming each year. Changes are so gradual as not to be noticed unless one makes careful comparisons of the forms of medical practice at different periods. As in the economic and political fields the transition from one viewpoint to another radically different one is scarcely appreciated.

The committee believes that a consistent and persistent cultivation of preventive opportunities in cooperation with public health agencies and throughout the whole of private practice is the sound and practical way to adapt the form of the practice of medicine to the future needs and also to raise its standards to the highest levels from the standpoint of human efficiency.

—OSMJ—

Edgar Sydenstricker, statistician of the U. S. Public Health Service, and for several years director of research for the Millbank Fund, has been appointed scientific director for the Millbank Fund.

—OSMJ—

Dr. A. Graeme Mitchell, professor of pediatrics, College of Medicine, University of Cincinnati, has been appointed administrative consultant to the Georgia Warm Springs Foundation. This will not interfere with his duties as medical director of the Cincinnati Children's Hospital Research Foundation, according to officials of the hospital.

ANNUAL REPORT OF THE COMMITTEE ON MILITARY AND VETERANS' AFFAIRS

LOUIS FEID, JR., *Chairman*.....Cincinnati
JOHN A. SIPHER.....Norwalk
A. J. MCCRACKEN.....Bellefontaine

CIVILIZED people generally cherish the hope that the time is not too far distant when international disputes will be settled amicably, rather than by war, with its terrible cost from the crippling and loss of human lives and destruction of property.

However, developments in the Far East and in Europe, and the fact that most countries are promoting increased military and naval programs make that Utopian ideal seem farther from realization than at the close of the World War.

Even our own country by recent congressional action made possible an increase in the enlisted personnel of the army from 118,000 to 165,000; the navy, from 82,500 to 93,500, and the marine corps from 14,900 to 16,000.

In addition, 600 new cadets are being sought for West Point and 250 officers for the marine corps. Navy line officer strength is to be increased from 5,499 to 6,531. These increases do not include the regular midshipman appointments for Annapolis or cadets for West Point; nor provisions for some increase in officer flying personnel authorized for the year 1935-1936.

These additions will bring the active national defense force to its greatest strength since the immediate post-war years. The $860,682,549 appropriated for national defense in the fiscal year, beginning July 1, 1935, is the largest defense fund voted by Congress since the World War period.

In view of all this, your committee feels that it is highly important that the medical profession, by continued interest in military affairs, be ready to assume the responsibility which only physicians can shoulder in the case of another national emergency.

It has been estimated that at least 50,000 physicians, in addition to those already enrolled in the Medical Corps and the Organized Medical Reserve Corps of the United States Army and Navy would be required to provide for proper medical care for the armed forces of the country in the event of a major conflict.

Your committee does not want its report to be construed as promoting a militaristic spirit within the medical profession. However, it does feel strongly that the profession must be prepared, so that if called upon for service, it will be ready.

The United States Government, through the Organized Army Officers Reserve Corps, the Naval Reserve Corps, and the Ohio National Guard, has provided adequate opportunities for physicians of military age to obtain the special training necessary to fit them for active duty.

ARMY RESERVE PROGRAM

Under the present War Department Mobilization Plan, 17 Medical Department Reserve units, located in the State of Ohio, are designated for mobilization on M-Day (or the day of mobilization). This number does not include National Guard or reserve units and detachments assigned to divisions or line troops. These units are classed as Non-Divisional Medical Department units and Regular Army Inactive units.

The distribution of the units throughout the state is as follows: Cleveland 8, Columbus 4, Cincinnati 3, and Toledo 2. As far as practicable, the personnel for the various units is drawn from the city and vicinity in which they are located.

Due to the abolishment of all R.O.T.C. Medical units, which have been the source of more than 50% of the new appointments in the Medical Reserve Corps, the War Department has amended regulations governing appointment in the Medical Reserve Corps so that all graduates of Class "A" Medical schools, who are physically fit, may, upon recommendation of the dean or president of the school, be appointed a first lieutenant, Medical Reserve Corps, immediately upon graduation.

In order to be eligible for promotion an officer must first obtain a Certificate of Capacity for Promotion. This certificate may be earned by taking a written examination in certain military subjects or satisfactory completion of such subjects in the Army Extension Courses and a practical test, the successful completion of which establishes the officer's eligibility for promotion when he has served sufficient time in grade and a vacancy occurs.

Army Extension Courses which cover a number of military subjects that would confront the citizen officer upon assuming his duties as an officer in the time of emergency are available to all Medical Reserve Officers.

OBJECTS OF EXTENSION SCHOOL

The object of the extension school is to fit the reserve officer who finds that he does not have time to devote to active duty training in peace time for the duties which would confront him in the time of war. On December 31, 1934, 433 Medical Department Reserve Officers, residents of the State of Ohio, were enrolled in the extension school, which represents an increase of 63 students over the preceding year.

In addition to regular extension courses, the Extension Course of Aviation Medicine is available to Medical Reserve Officers. Upon completion of this extension course officers are detailed to

duty at the School of Aviation Medicine, Langley Field, Virginia, for a practical course of six weeks and upon completion of both courses are rated as flight surgeons.

Since the beginning of the Civilian Conservation Corps early in 1933, 128 Medical Reserve Officers have been ordered to active duty as camp surgeons for CCC camps. On December 31, 1934, 53 of these officers were remaining on duty.

The procurement quota for Medical Department Reserve Officers of the Fifth Corps Area (Ohio, Indiana, Kentucky and West Virginia) has not been attained. There are vacancies in every branch of the Medical Department except the dental and sanitary corps.

The following figures furnished your committee by Lieutenant Colonel W. B. Borden, Acting Surgeon, Fifth Corps Area, Fort Hayes, Columbus, shows the distribution of Ohioans enrolled in the medical units and groups of the Army Officers Reserve Corps at the end of 1934, and for comparison, 1933:

ACTIVE, CORPS AREA ASSIGNMENT GROUP
(Under Corps Area Commander)

Corps	Colonels	Lt. Cols.	Majors	Capts.	1st Lts.	2nd Lts.	Totals 1934	1933
Medical	18	37	62	55	543		715	715
Dental	1	1	19	41	303		365	379
Sanitary				3	5	3	11	12
Veterinary		1	5	5	5	69	85	87
Med. Adm.				8	21	48	77	75
Totals	19	39	86	112	877	120	1253	1268

INACTIVE, CORPS AREA ASSIGNMENT GROUP
(Under Corps Area Commander)

Medical			7	10	80		97	107
Dental			2	6	31		39	46
Sanitary				1			1	1
Veterinary				1	2	4	7	7
Med. Adm.					1	13	14	15
Totals			9	18	114	17	158	176

ACTIVE, ARM AND SERVICE ASSIGNMENT GROUP
(Under Chief of Branch)

Medical			1	4	4		9	16
Dental				2	2		4	4
Sanitary			3	3			6	8
Veterinary			1	2		1	4	3
Med. Adm.					1	1	2	2
Totals			5	11	7	2	25	33

INACTIVE, ARM AND SERVICE ASSIGNMENT GROUP
(Under Chief of Branch)

Medical			7	9	80		96	7
Dental			2	4	28		34	1
Sanitary								0
Veterinary				2	1	4	7	1
Med. Adm.				1	2	13	16	2
Totals			9	16	111	17	153	11

NEW APPOINTMENTS IN 1934

Medical	Dental	Sanitary	Veterinary	Med. Adm.	Total	1933
108	28	0	16	4	156	192

PROMOTIONS IN 1934

Medical	Dental	Sanitary	Veterinary	Med. Adm.	Total	1933
6	7	1	4	1	19	31

NAVAL RESERVE UNITS IN OHIO

The headquarters for Naval Reserve Activities in the State of Ohio is the office of the Commander First Naval Reserve Area, Ninth Naval District, 794 Leader Building, Cleveland, Ohio. The headquarters for the Ninth Naval District, which includes in its organization thirteen (13) states in the Middlewest, is the office of the Commandment, Ninth Naval District, Great Lakes, Illinois.

Naval Reserve Officers are classed into three groups, as follows, for the purpose of organization, training and assignment:

1. Fleet Naval Reserve.
2. General Service Naval Reserve.
3. Special Service Naval Reserve.

The mission of the Naval Reserve is to procure, organize, and train the officers and men necessary, in event of war, for the expansion and operation of the United States Fleet and Naval Transportation Service.

The following charts show the number of Naval Reserve Medical and Dental Officers, of all classes, now enrolled in the First Naval Reserve Area, that is, the State of Ohio.

MEDICAL (Naval Reserve)

Rank	Fleet Reserves	General Service	Special Service	Total
Commanders		1	1	2
Lt. Commanders		2	13	15
Lieutenants	2	2	16	20
Lieutenants (Junior Grade)	4	4		8
Total	6	9	30	45

DENTAL (Naval Reserve)

Lt. Commanders		1	1
Lieutenants	2	1	3
Lieutenants (Junior Grade)	1	1	2
	3	3	6

Most of the Special Service Officers are assigned to Naval Specialist Units. These units in time of war will be assigned to Naval Base Hospitals, Hospital Ships and Medical Regiments and are composed as follows: one surgeon; one internist; one opthal-oto-laryngologist; one urologist; one clinical pathologist; one roentgenologist; one psychiatrist; one orthopedist; one orthodontist or prosthodontist.

As there are seven such units located in Ohio there are vacancies in almost every speciality. Any physician is qualified and those wishing to secure a commission in one of the specialities branches is urged to communicate with the Commander, First Naval Reserve Area, Cleveland, Ohio.

It is strongly recommended that all physicians of military age, especially those with previous

military experience, avail themselves of the opportunities for practical training and commissions offered by the Organized Medical Reserve Corps and the Ohio National Guard.

Detailed information concerning the medical units of the National Guard and its training periods and facilities may be obtained from Adjutant General Emil F. Marx, State House, Columbus Applicants for commissions in the Army Organized Reserve Corps should be sent to Lt. Colonel W. B. Borden, Acting Surgeon, Fifth Corps Area, Fort Hayes, Columbus.

VETERANS' PROGRAM WATCHED

Your committee has kept in touch with the Federal Government's program of medical and hospital care for veterans.

There have been no developments that would lead us to advocate any modification at this time of the policy of the Ohio State Medical Association with respect to the medical and hospitalization aspects of the veterans' program.

We believe that adequate provision should be made by the Federal Government for ex-service men whose physical disabilities were incurred in, or resulted from, active service, and for the dependents of those who died in service.

We believe those suffering from non-service connected disabilities should not be entitled to medical and hospital care at the expense of the Federal Government unless they are able to show to the satisfaction of the Veterans' Administration that they are unable financially to provide such services for themselves.

We believe the Federal Government should continue its present policy of not erecting new hospitals for the care of veterans, inasmuch as present facilities are quite adequate to meet the present needs in this respect.

We recommend that the State Association and all county medical societies follow the example set by the American Medical Association in establishing a cordial and cooperative relationship with various veterans' organizations so that medical organization and such veterans' groups can work together for the best interests of ex-service men and the medical profession generally.

ANNUAL REPORT OF THE COMMITTEE ON AUDITING AND APPROPRIATIONS

(Combined with Annual Report of the Treasurer, James A. Beer, M.D.)

B. J. HEIN, Chairman.....Toledo
H. S. DAVIDSON.....Akron
A. A. JENKINS.....Cleveland

YOUR Committee on Auditing and Appropriations is pleased to report that the Ohio State Medical Association ended the calendar (fiscal) year 1934 with its financial affairs in an exceptionally sound condition.

It should be gratifying to the membership to know that through careful management, sound judgment and rigid economy, the machinery of organized medicine in Ohio was operated during one of the most troublesome and uncertain periods in all history without financial embarrassment and with such efficiency that additional benefits were provided for the membership, individually and collectively, and the State Association was able to materially extend its services to all members.

The budget for the calendar year 1934, formulated by the Committee on Auditing and Appropriations and adopted by the Council, provided for economies in the operation of the State Association. However, it took into consideration essential and desirable activities and provided adequate appropriations for financing them.

Through curtailments in expenditures, and despite the loss of revenue from a decrease in *Journal* advertising, the State Association concluded 1934 with a small current balance.

All expenditures for 1934 were kept well within the budgetary allowances. This resulted from special vigilance and supervision on the part of the Committee on Auditing and Appropriations and exceptional efficiency and wholehearted cooperation on the part of our State Headquarters Office personnel.

As indicated by the audit of State Association and *Journal* records for 1934 by a firm of certified public accountants (appended to this report), an accurate account was kept of all financial transactions. The bookkeeping was handled efficiently. No expenditures were made until after careful investigation by and upon authorization of the Committee on Auditing and Appropriations. Inactive and reserve funds were carefully invested. In general it may be said that the resources of the State Association have been handled carefully and judiciously and in accordance with regulations which compare with those governing trust agreements.

Shortly before the first of the current year, the Council devoted a careful study to the financial needs of the State Association, as well as to anticipated problems. It adopted a budget for 1935 which was based on sound economic principles, good business judgment, and forward-look-

ing organization procedure. (Council minutes, January, 1935, issue *The Journal*).

The 1935 budget was comparable in most respects to that for 1934. Adequate provision was made for important and necessary organization activities. A small contingent appropriation was authorized to provide, if necessary, additional funds for emergencies in connection with legislative activities, research, special field work, etc.

So far we have not been compelled to draw upon these emergency funds but anticipated problems between now and the end of the year may make this necessary.

At present the financial condition of the State Association and *The Journal* is satisfactory. The revenue of the State Association from membership enrollment has increased. An increase has taken place in *Journal* advertising revenue. A considerable saving in fixed expenditures occurred as a result of changes in the personnel of our State Headquarters Office.

However, we should like to point out to the membership that it is doubtful if the State Association will do more than break even financially this year and there is a possibility that we may find it necessary to utilize some of our reserve funds for current expenditures. There are several reasons for this situation.

The $1-per-member rebate on membership dues made upon authorization of the Council will consume by the end of the year approximately one-sixth of our total revenue for 1935.

Last Spring the Council voted to give financial assistance to the district societies, upon request, to help them defray the cost of district meetings. This is a worthy undertaking on the part of the State Association and should be continued. However, it should be remembered that this may amount to between $1,000 and $1,500 by the end of the year. Moreover, it should be noted that this expenditure was not anticipated when the 1935 budget was formulated and not provided for in it.

The costs of office supplies, printing, equipment, etc., have increased. The correspondence of our headquarters office has been unusually heavy because of serious state-wide problems, resulting in increased expenditures for postage, stationery, etc.

In addition, and to repeat, there is a strong probability that medical organization will be called upon during the ensuing months to expand its public activities and field work to meet critical social and governmental problems affecting the medical profession and the practice of medicine.

We cannot anticipate at this time the amount of money which will be needed to carry on these activities.

However, we wish to assure the membership that the committee will not adopt a miserly attitude in handling the financial affairs of the State Association in these times when critical problems must be solved and medical organization must be maintained at the peak of efficiency.

If it is necessary for the State Association to draw upon its reserve funds to meet extraordinary situations and emergencies, this committee will have no hesitance about recommending and authorizing such expenditures.

If during ensuing months it is found desirable and expedient that the State Association extend the scope of its activities and engage in undertakings that will necessitate an increased financial outlay, this committee will gladly cooperate to the extent of its authority.

The membership, we are sure, realizes that the Ohio State Medical Association at present offers more services and relatively greater benefits to its members in proportion to the amount of the annual dues than any other state medical association and probably any other professional or business organization.

Also the membership must realize that the Association must expand to meet increased responsibilities falling on organized medicine. The State Association is obligated to take every possible step to protect the interests of the profession and the public. If this means the extension of activities and the addition of new services, these should be undertaken.

If, as some anticipate, it is desirable for the State Association to enter new fields of activity and increase its usefulness to the membership, additional revenues will have to be provided, perhaps through a small increase in membership dues. We are not recommending that at this time, but we do feel that it is a matter that merits serious thought and, of course, will have to be decided in accordance with future developments and problems.

ACCOUNTANTS' REPORT RE STATE ASSOCIATION

Chairman, Auditing Committee,
Ohio State Medical Association,
Columbus, Ohio.

Dear Sir:

In accordance with your instructions we have audited the books of the Ohio State Medical Association for the year ended December 31, 1934, and submit herewith our report, including as a part thereof the following described schedules:

SCHEDULE A—Statement of the Cash Receipts and Disbursements for the year ended December 31, 1934.—Treasurer.

SCHEDULE B—Statement of Cash and Bond Reconciliation at December 31, 1934.—Treasurer.

SCHEDULE C—Statement of Cash Reconciliation—Executive Secretary at December 31, 1934.

AUDIT—All recorded cash was traced to the depository. Disbursements were verified by examination of cancelled checks, supported by vouchers properly approved. Cash on Deposit at December 31, 1934, as shown by certificates from the banks, was reconciled with the balance as shown by the books at that date.

United States bonds and certificate of deposit were verified by inspection.

CERTIFICATE—We therefore certify that, in our opinion, subject to the foregoing comments, the statement herein contained correctly states the cash receipts and disbursements of the treasurer of the Ohio State Medical Association for the year ended December 31, 1934.

Respectfully submitted,

KELLER, KIRSCHNER & MARTIN,
Certified Public Accountants.

SCHEDULE A—STATEMENT OF THE CASH RECEIPTS AND DISBURSEMENTS—TREASURER—FOR THE YEAR ENDED DECEMBER 31, 1934.

Cash on Hand and on Deposit at January 1, 1934		$ 3,302.59
United States Bonds		69,000.00
Total Cash and Bonds, Jan. 1, 1934		$ 72,302.59
Receipts		
Membership Dues—1934	$26,593.00	
Membership Dues—1933	89.50	
Annual Meeting	2,200.00	
Unexpended balance from A. M. A. Meeting Apprn.	319.02	
Interest	2,752.56	
Total Receipts		31,954.08
Total to be accounted for		$104,256.67
Disbursements		
Ohio State Medical Journal	$ 6,000.00	
Executive Secretary—Salary	6,600.00	
Executive Secretary—Expense	755.62	
Assistant Executive Sec'y—Salary	4,000.00	
Assistant Executive Sec'y—Expense	134.23	
President's Expense	209.83	
Treasurer's Salary	300.00	
Council	431.23	
Annual Meeting	1,874.51	
American Medical Ass'n Meeting	1,500.00	
Auditing	100.00	
Committee on Public Policy	791.06	
Medical Defense	1,821.34	
Miscellaneous Committee Expense	47.70	
Stationery and Supplies	340.46	
Postage and Telegraph	729.65	
General Counsel—Salary	2,100.00	
Total Disbursements		$ 27,735.63
Cash on Hand, on Deposit, and Bonds at December 31, 1934		76,521.04
Total accounted for		$104,256.67

SCHEDULE B—STATEMENT OF CASH AND BOND RECONCILIATION—TREASURER—AT DECEMBER 31, 1934

The Huntington National Bank

Balance as shown by bank statement December 31, 1934		$ 3,172.86
Less Outstanding Checks		651.82
Balance as shown by books at December 31, 1934		$ 2,521.04
Government Bonds and Certificates of Deposit		
U.S. Liberty Bonds 4¼ Registered	$ 5,000.00	
U.S. Treasury Bonds 4¼—3¼	20,000.00	
U.S. Treasury Bonds 3⅜	19,000.00	
U.S. Treasury Bonds 3⅜	25,000.00	
Certificate of Deposit—Huntington National Bank	5,000.00	74,000.00
Total balance as shown by books at December 31, 1934		$ 76,521.04

SCHEDULE C—STATEMENT OF CASH RECONCILIATION—EXECUTIVE SECRETARY—AT DECEMBER 31, 1934.

The Ohio National Bank

Executive Secretary (Dues Account)	
Balance as shown by bank statement December 31, 1934	$ 10,164.62
Less Outstanding check to Treasurer	57.50
Balance	$ 10,107.12

Ohio State Medical Association Records

1935 Dues deposited in 1934	$ 10,107.00
Tax on Checks returned	.12
Balance as shown by records Dec. 31, 1934	$ 10,107.12

ACCOUNTANTS' REPORT RE THE JOURNAL

To the Committee on Auditing of the
Ohio State Medical Association,
Columbus, Ohio.

Gentlemen:

In accordance with your instructions we have audited the books of the *Ohio State Medical Journal*, for the year ended December 31, 1934, and submit herewith our report, including as a part thereof the following described schedules:

SCHEDULE A—Balance Sheet at December 31, 1934.

SCHEDULE B—Statement of Revenue and Expense for the year ended December 31, 1934.

Financial Condition

The financial condition of the *Ohio State Medical Journal* at December 31, 1934, (as shown in detail in Schedule A) was as follows:

Cash on Hand and on Deposit	$ 1,091.15
Accounts Receivable	871.50
Total Current Assets	$ 1,962.65
Less Current Liabilities	19.00
Net Current Assets	$ 1,943.65
Furniture and Fixtures	1,975.77
Total Net Assets	$ 3,919.42
The above is represented by:	
Surplus	$ 3,919.42

AUDIT—All recorded cash was traced to the depository. Disbursements were verified by examination of cancelled checks, supported by properly approved invoices. Cash on deposit at December 31, 1934, as shown by a certificate from the bank, was reconciled with the balance as shown by the books at that date. Petty cash vouchers were checked and the amount of petty cash on hand was verified by count as of a present date during the audit.

CERTIFICATE—We therefore certify that, in our opinion, subject to the foregoing comments, the statements herein contained correctly state the financial condition of the *Ohio State Medical*

Journal at December 31, 1934, and the revenue and expense for the year ended on that date.

Respectfully submitted,

KELLER, KIRSCHNER & MARTIN,
Certified Public Accountants.

SCHEDULE A—BALANCE SHEET AT DECEMBER 31, 1934.

ASSETS

Current Assets

Cash—The Ohio National Bank	$1,081.15	
Cash—Petty	10.00	
Total Cash		$ 1,091.15
Accounts Receivable		871.50
Total Current Assets		$ 1,962.65
Property Assets		
Furniture and Fixtures		1,975.77
TOTAL ASSETS		$ 3,938.42

LIABILITIES

Current Liabilities

Subscriptions Prepaid	$ 19.00

SURPLUS

Surplus at December 31, 1933	$3,226.02	
Add—Revenue in excess of expense for the year ended December 31, 1934	693.40	
Surplus at December 31, 1934		3,919.42
TOTAL LIABILITIES AND SURPLUS		$3,938.42

SCHEDULE B—STATEMENT OF REVENUE AND EXPENSE FOR YEAR ENDED DECEMBER 31, 1934

Revenue

Advertising		$9,380.50	
Less—Commissions	$823.67		
Cash Discount	270.88	1,094.55	$ 8,285.95
Circulation			6,000.00
Miscellaneous			91.15
Total Revenue			$14,377.10

Expenses

Journal Printing	$6,944.49	
Office Salaries	3,720.00	
Rent	1,500.00	
Journal Postage	435.59	
Telephone and Telegraph	118.34	
Depreciation	207.13	
Journal Envelopes	243.44	
Office Supplies and Expense	163.03	
Stencils and Mimeograph Supplies	52.78	
Dues and Subscriptions	108.00	
News Clipping Service	78.00	
Express and Delivery Service	13.35	
Repairs and Cleaning	58.25	
Halftones and Etchings	6.00	
Golf Trophy—Medical Meeting	34.50	
Total Expense		$13,683.70

Revenue

In excess of Expense for the year ended December 31, 1934	$ 693.40

ANNUAL REPORT OF THE COUNCILORS

INNUMERABLE difficult and complex questions have been considered by the Council since the last Annual Meeting of the State Association.

A review of these questions and the action of the Council on them will not be included in this report. They are recorded in the official minutes of Council meetings published in the January, April, May, July and September, 1935, issues of *The Ohio State Medical Journal* and referred to in the reports of the various standing and special committees of the State Association.

Having been in close and constant touch with the problems and difficulties confronting the medical profession, the Council is strongly impressed with the need for and importance of aggressive, united and efficient medical organization. This is more true today than ever before.

Serious questions of direct interest to the medical profession of Ohio have been satisfactorily solved and critical situations averted because the medical profession is strongly organized and maintains effective organization machinery.

How to strengthen our forces and increase our effectiveness is a question which demands the consideration of every member.

The difficulties confronting the profession cannot be alleviated by individual effort. They must be subjected to organized attack. This has been demonstrated repeatedly during the past year. A few individuals promoted to the ranks of leadership cannot be expected to shoulder the entire burden. They can do much but to attain satisfactory results they must have the backing and active assistance of the membership, working individually and through their county medical societies and academies of medicine in the interests of organized medicine, which, of course, means for the medical profession generally.

This leads to the observation that the county medical society is the most important unit of medical organization and the vital cog in the organization machinery of the medical profession.

It is recommended that increased efforts be made during the coming year to strengthen every county society and academy. Many of the problems confronting the profession must be met locally and handled in the light of local conditions and local needs. The Council can assist the local medical societies, and is anxous to do so, but in many instances definite decisions must be made by the local units. The Council can initiate new activities for organized medicine but their success will depend largely on the degree of backing given by the county societies. The Council can combat forces trying to undermine the profession but its efforts will be comparatively feeble unless it receives vigorous support from the local units.

Occasionally, a county society's influence in the community is nullified because the majority of its members refuse to exercise any aggression or initiative in local community affairs and have the misconception that it is the business of somebody else to fight their battles for them.

Every county society should have an alert and aggressive Public Relations Committee and every member should be made to feel it is an obligation on his part to give this committee full support and cooperation.

The Council cannot perform duties and assume responsibilities which are primarily those of county societies or individual members. Each county society has a part in the program of organized medicine. If one is negligent the efforts of the rest will be less fruitful. Each member owes an active interest in medical organization to his local society and the State Association. Each member should be ready to assume some responsibility in the activities of his local and state society and frequently offer constructive criticism on ways to strengthen and improve medical organization.

The Council not only welcomes but requests comments from the membership. It will give serious thought and consideration to all received. Our policy during the ensuing year will be the same as that of the past 12 months: To be consistent and constructive; to give all questions thorough study; to try to serve the best interests of the profession in all our activities and procedures; to base our decisions on existing policies laid down by the House of Delegates of the State Association; to endeavor to properly interpret the sentiment and viewpoint of the majority of the members; and to attempt to conscientiously and intelligently meet our obligation to the membership.

In conclusion, the Council suggests:

1. That every member read carefully, if he has not already done so, the minutes of the Council meetings held during the year inasmuch as they are an official resume of many of the important activities of organized medicine in Ohio for the past year.

2. That every member take a renewed and increased interest in his local society and the State Association. Effective organized activity is necessary to safeguard the interests of the profession.

3. That each county medical society attempt to enroll every eligible and qualified physician in its jurisdiction. Strength is measured in quantity as well as quality.

4. That closer contact be maintained during the coming year between the Council and the various county medical societies and between the individual members of the Council and the members of the different districts.

The members of the Council are vitally interested in the activities and problems of the societies in their districts. They are eager at all times to assist the local societies and submit their difficulties to the Council as a whole for consideration and action.

There should be mutual cooperation between councilors and societies. County societies should keep in close touch with the councilor of the district; keep him informed on local developments and situations; and relay to him suggestions and comments offered by individual members on various questions of interest to the profession as a whole.

5. That all members frequently transmit to the Council, officers and committee chairmen comments and observations, advice and factual data which will be valuable in consideration of the many and varied questions coming before the Council.

6. That all members retain their confidence in the value and importance of medical organization; actively assist in strengthening it; and give to those selected to positions of leadership, their full and active cooperation and assistance.

Following is a summary of the membership figures of the various county societies, divided by districts for most of the calendar year 1935. It is gratifying to note a steady increase has taken place in the membership of the State Association in the past year, indicating that the profession of the state generally is well aware of the innumerable benefits and services offered by medical organization.

MEMBERSHIP DATA

First District

Parke G. Smith, M.D., Councilor, Cincinnati

County	Paid Membership 1934	to 9-10-35
Adams	16	16
Brown	5	7
Butler	74	76
Clermont	21	20
Clinton	24	27
Fayette	14	15
Hamilton	595	638
Highland	21	22
Warren	22	21
	792	842

Second District

E. M. Huston, M.D., Councilor, Dayton

Champaign	21	17
Clark	71	68
Darke	32	32
Greene	33	37
Miami	51	48
Montgomery	270	283
Preble	17	18
Shelby	20	20
	515	523

Third District

O. P. Klotz, M.D., Councilor, Findlay

Allen	67	68
Auglaize	29	30
Hancock	41	43

County	Paid Membership 1934	to 9-10-35
Hardin	24	24
Logan	23	26
Marion	40	40
Mercer	16	19
Seneca	32	33
Van Wert	21	20
Wyandot	13	9
	306	312

Fourth District

B. J. Hein, M.D., Councilor, Toledo

Defiance	18	14
Fulton	17	18
Henry	15	13
Lucas	241	217
Ottawa	11	16
Paulding	12	11
Putnam	25	26
Sandusky	33	34
Williams	18	15
Wood	35	33
	425	397

Fifth District

A. A. Jenkins, M.D., Councilor, Cleveland

Ashtabula	41	39
Cuyahoga	964	932
Erie	33	36
Geauga	9	10
Huron	21	17
Lake	22	28
Lorain	104	101
Medina	21	22
Trumbull	45	44
	1260	1229

Sixth District

H. S. Davidson, M.D., Councilor, Akron

Ashland	23	21
Holmes	9	8
Mahoning	195	194
Portage	27	27
Richland	59	53
Stark	182	172
Summit	258	274
Wayne	43	40
	796	789

Seventh District

C. W. Kirkland, M.D., Councilor, Bellaire

Belmont	50	55
Carroll	(with Stark Co. Sec.)	
Columbiana	50	52
Coshocton	25	23
Harrison	10	11
Jefferson	50	52
Monroe	7	7
Tuscarawas	46	47
	238	247

Eighth District

E. R. Brush, M.D., Councilor, Zanesville

Athens	39	37
Fairfield	36	36
Guernsey	32	31
Licking	49	48
Morgan	12	11
Muskingum	49	53
Noble	1	1
Perry	19	19
Washington	42	39
	279	275

Ninth District

I. P. Seiler, M.D., Councilor, Piketon

Gallia	22	23
Hocking	14	16
Jackson	12	13
Lawrence	20	23
Meigs	14	12
Pike	7	8
Scioto	70	68
Vinton	5	6
	164	169

Tenth District

S. J. Goodman, M.D., Councilor, Columbus

Crawford	28	29
Delaware	23	23
Franklin	415	399
Knox	29	24
Madison	12	14
Morrow	10	9
Pickaway	15	12
Ross	38	32
Union	17	16
	587	558
Grand Total	5362	5341

—OSMJ—

National Health Campaign

The National Health Council, headed by Colonel Theodore Roosevelt, is sponsoring a campaign to improve the nation's physical condition.

The Council subscribes to the following policy:

1. Stimulation of intelligent interest in community health on the part of American citizens.

2. Coördination of health and social agencies, local and state, in campaigns to express interest in community health.

3. Unification of national health agencies in the National Health Council to promote the foregoing objectives.

It is expected that programs of community health education will be presented in assemblies in 400 cities during the month of October, when the drive ends.

—OSMJ—

Dr. T. Wingate Todd, Cleveland, was to address the Section on Pediatrics, Medical Society of the State of Pennsylvania, at its eighty-fifth Annual Session, at Harrisburg, Pa., Sept. 30 to October 3, 1935, on the subject, "The Clinical Significance of Skeletal Roentgen-Ray Assessment in Children".

—OSMJ—

The American Board of Orthopedic Surgery announces that its next examination will be held in St. Louis in January, 1936. Candidates interested in the activities of the board may obtain information by writing the secretary, Dr. Fremont A. Chandler, 180 North Michigan Ave., Chicago, Illinois.

LOCAL SUBDIVISIONS CONFRONTED WITH SERIOUS RELIEF PROBLEM AS FERA WITHDRAWS FINANCIAL AID; PROMPT ACTION BY COUNTY MEDICAL SOCIETIES IMPERATIVE

FOLLOWING the announcement of Harry L. Hopkins, FERA Administrator, that the Federal Government will discontinue the allotment of funds for direct relief, including medical care, by November 1, the Ohio headquarters of the FERA has started to turn over to counties which are able financially to handle the job, the responsibility of providing for the care of its indigents and temporarily unemployed.

Effective September 15, the following counties were instructed to assume responsibility for direct relief activities and notified that they would receive no more financial aid from the Federal Government: Harrison, Auglaize, Brown, Carroll, Champaign, Madison, Pickaway, Putnam, Wayne, and Fulton.

The following counties have been notified that after October 1 they will not receive FERA funds for direct relief: Darke, Knox, Fairfield, Williams, Tuscarawas, Defiance, Henry, Mercer, Muskingum and Union.

MORE CUTS IN PROSPECT

The direct relief allotments to all counties were reduced approximately 15% on September 1. The August allotments had been reduced between 35 and 50%. Allotments for October to counties still eligible to receive Federal funds doubtless will be drastically decreased.

Funds for medical care have been, and will continue to be, decreased in proportion to the reduction ordered in the budget for direct relief generally.

FERA officials state that the medical program established under FERA Rules and Regulations No. 7 will be continued as long as the FERA provides funds for direct relief.

If the FERA follows its contemplated plan, the present state-wide medical program will expire on November 1 and each county will be expected to set up its own system to provide medical services for the needy and unemployed.

At present no figures are available as to the number of persons who will have to be cared for throughout the state or individual counties.

NO STATE PROGRAM DRAFTED

Poor relief officials hope that by November 1, approximately 257,000 employable persons now on relief in Ohio will have been put to work on projects of the Works Progress Administration and the Public Works Administration or absorbed by private industry, leaving approximately 56,000 families which will have to be provided for by the state or local subdivisions for an indefinite period.

No definite plans had been made by the state administration to meet the situation up to the time this was written.

Under the provisions of the Carey Act, passed at the regular session of the General Assembly this year, counties may issue poor relief bonds, pledged against revenue from the 1% utilities excise tax.

However, a recent ruling of the Ohio Supreme Court holds that such bonds must be inside the 10-mill general tax limitation unless specifically approved by the voters.

This decision has prevented some counties from taking advantage of the Carey Act.

Special elections have been held in some counties on this proposition and some counties are planning to hold such elections in the near future.

IMMEDIATE NEEDS CITED

On August 30, a state-wide delegation of welfare and relief officials, headed by Marc Grossman, chairman of the Cuyahoga County Relief Commission, called on the Governor to urge that the legislature be convened in special session immediately to consider the problem of direct relief.

The committee estimated that at least $23,060,000 would be needed to care for indigents from November 1, 1935, to December 31, 1936, apportioned as follows: For the care of 56,000 families on direct relief (on a basis of $25.00 per month) $19,060,000; for necessary supplements to wages, health and other emergency needs, $1,960,000; and care of homeless transients, $1,500,000.

It was estimated that approximately $10,000,000 could be provided through the Carey Act, leaving $13,000,000 as the state's share.

Neither the delegation nor the Governor had a specific plan for producing this sum, although the Governor did say that he would submit a "stop-gap" relief program to the legislature at its first special session, and a more comprehensive program to another special session to be called for the purpose of considering the taxation muddle.

Incidentally, the Governor stated that many state functions, including old age pensions and schools were facing a crisis, and that it would be up to the Legislature to provide approximately $50,000,000 in tax revenues to care for all these functions.

COUNTIES, CITIES MUST BEAR THE LOAD

Present indications are that the major portion of the direct relief burden will have to be borne by the individual counties, with some supplemental relief from state funds.

For that reason, and as emphasized in previous issues of *The Journal*, it is essential that the medical advisory committee or other proper committee of every county medical society and academy of medicine immediately contact county, municipal and township officials; suggest immediate conferences on the question of medical relief; and offer the cooperation of the medical profession and definite recommendations in connection with establishing a local medical relief set-up.

Moreover, inasmuch as the FERA is about to withdraw from the field of direct relief, it is important that all physicians who have been and are now rendering medical care to those on relief, submit their fee bills to their local FERA director promptly to insure early payment and if possible before the FERA shuts down on direct relief.

The Committee on Public Policy of the State Association is keeping in close and constant touch with the FERA headquarters in Columbus and with state officials for the purpose of offering advice on this situation and securing information for dissemination to the officials of the various county medical societies.

SOME MEDICAL SOCIETIES BUSY

Correspondence received at the Headquarters Office of the State Association indicates that the medical advisory committees and public relations committees of a number of county medical societies have contacted local governmental officials on this matter and are working with them in an effort to evolve some relief program which will meet local needs.

As one county society officer stated in his letter: "Here is an opportunity for us to make our local officials realize the importance of a sound medical relief set-up and the importance of compensating physicians in an equitable manner; and work out a program which will eliminate, if possible, the bad features of the one which has been in operation for the past two years."

ASKED TO ASSIST WPA OFFICIALS

Presidents and secretaries of the county medical societies in Ohio recently received a communication from Charles C. Stillman, WPA administrator in Ohio, requesting their cooperation in the administration of the government's program for medical care of men injured on WPA projects.

The county societies have been asked to submit to Glen I. Hay, State Compensation Officer, a list of recommended physicians, who are especially well-qualified by training and experience to render service in industrial accident cases, and who desire to participate in this service, under the regulations of the United States Employes' Compensation Commission.

Some county societies already have submitted such a list. It is hoped that all societies will comply promptly with Mr. Stillman's request.

Ohio physicians who expect to render medical care in WPA injury cases, should read carefully the rules and regulations governing medical care of injured WPA workers, explained in detail on Pages 701-3 of the September issue of *The Journal*.

ADVICE ON HANDLING FORMS

It will be noted that instructions have been issued to reduce the paper work required of physicians to a minimum.

Physicians will be required to fill out and sign only the original copy of the following forms, which will be delivered to him by the WPA project foreman or the injured employe:

CA-16—Authority for treatment.

or

CA-17—Authority for emergency treatment in cases where there is doubt whether the disability is due to an injury sustained in the performance of duty, including cases of hernia and back strain.

S-69—Voucher for medical service.

CA-32—Special form to be used in conjunction with CA-17 on hernia cases.

PROMPT FILING ESSENTIAL

The medical report on CA-2, the foreman's report of injury, need not be filled out by the physician if he has filled out forms CA-16 or CA-17.

If an injured employe requests compensation, he must present his request on Form CA-4, or CA-8 for continuing compensation, to the attending physician for signature. In compensation cases, the state compensation officer requests that the attending physician send in CA-16 or CA-17 to the district compensation officer, without waiting for the completion of Forms CA-4 or CA-8, or S-69, voucher for medical service, in which case it will not be necessary for the physician to fill out another form CA-16 or CA-17 when he submits Form S-69.

When a physician is ready to discharge an injured employe from treatment, he should obtain the employes' signature on Voucher Form S-69, and forward it, with his charges properly itemized, together with Form CA-16 or CA-17, to the district compensation officer.

A list of the WPA districts, the counties comprising them and the location of the headquarters officers, appears on pages 700-1 of the September issue of *The Journal*.

Physicians can expedite payment of their bills if they will comply carefully with the WPA regulations, and file their bills promptly with the nearest compensation officer.

All payments for medical care of injured WPA employes will be made direct to the physician from the United States Employes' Compensation Commission, Washington, D. C.

REORGANIZATION OF THE STATE DEPARTMENT OF HEALTH IS SUGGESTED IN SHERRILL REPORT; STATE MEDICAL BOARD LAUDED; NEEDS MORE PERSONNEL, EQUIPMENT

THE Ohio Government Survey Committee, headed by Colonel C. C. Sherrill, Cincinnati, late in August presented two more reports to Governor Davey which should be of special interest to Ohio physicians.

They covered studies made of the operation of the State Department of Health and the State Medical Board.

The committee's report on the State Industrial Commission was summarized in the September issue of *The Journal*, pages 704-705.

The report pertaining to the State Department of Health stated that this department has functioned efficiently as a service organization, but "has not been an inspiring force in the development of public health work throughout the state due chiefly to lack of skilled leadership and lack of continuity of policy; the 'exemption privilege' granted the Director; the unworkable condition of the subsidy fund; and drastic budget cut".

It is pointed out that "appointment to the office of Director is a political reward and not a recognition of outstanding ability to fill the needs of the office".

Mention is made of the fact that none of the four physicians who have held the office during the 14 years prior to 1935 has had any assurance of tenure for any specified period and that "any progress made has been accomplished under those directors who have been willing to accept the advice of certain subordinates who have given the state long and faithful service".

"Continuity of policy, with most economical use of public funds, can never be assured under this system of appointment and tenure," the report declared.

PRINCIPAL CRITICISMS AMPLIFIED

Amplifying other principal criticisms of the Department set-up, the report stated:

"Each incoming Director has the right to remove any three positions from the classified list—to exercise the 'exemption privilege'. To the great credit of all directors of the past 14 years, no competent employee has been removed for political reasons. This risk, however, still remains.

"The granting of this fund (subsidy fund) in 1919 by the General Assembly was a constructive move, although the assembly has never appropriated a sufficient sum to pay, in full, the amounts prescribed by the Hughes-Griswold Act. Maximum benefit, moreover, has been obstructed by stipulations which prevented distribution to local health departments on any logical basis, such as per capita, need, or merit.

"These (budget cuts) have eliminated not only a large proportion of the personnel engaged in educational activities—10 of 13 nurses, for example—but have severely handicapped the whole Department through deficiency in personnel, transportation funds, and equipment."

SEVEN SPECIFIC RECOMMENDATIONS

Seven specific recommendations were made in the report, which the Committee estimates will result in a net annual savings of $6,888.50 and increase the efficiency of the Department.

They were as follows:

1. *That the appointment, removal, and term of office of the Director conform to the following procedure:*

(a) Appointment of the Director by the Governor to be from a list of qualified individuals recommended to him and approved by the Public Health Council; removal of the Director by the Governor to have the approval of the Public Health Council.

(b) Require that the office of the Director shall be indeterminate and that he may be removed only for incompetency, bad behavior, or age limitation.

2. *That another position—that of Assistant Director of Health—be created.*

"This man to be an experienced and otherwise well-qualified health officer; his appointment to be subject to the same conditions as in the case of the Director.

"Require that the term of office of the Assistant Director shall be indeterminate and he may be removed only for incompetency, bad behavior, or age limitation.

"The staffs of the present Division of Communicable Diseases, Division of Hygiene, and Bureau of Local Organization in the present Division of Administration, to report directly to this official.

"Increased annual expense for salary of additional Assistant Director—$6,000."

3. *That the Department be reorganized as follows:*

(a) Combine the present Division of Communicable Diseases and the Bureau of Occupational Diseases (now in the Division of Hygiene) into the Division of Preventive Medicine.

(b) Make the present Bureau of Local Health Organization, a Division, to include the Bureau of Child Hygiene and the Bureau of Dental Hygiene (now in the Division of Hygiene) and the Bureau of Public Health Nursing (now in the Division of Administration).

It was suggested that additional personnel for the new Division of Preventive Medicine and the new Local Health Organization, comprise the following: Epidemiologist, $3,600 per annum; dental health officer, $3,600 per annum; public health nurse supervisor, $3,000 per annum; three public health nurses, aggregating $5,400 per annum.

4. *That the subsidy now paid by the State to 186 health districts be distributed on the basis of their need and efficiency, the redistribution to be made at the discretion of the Director of Health, with the approval of the Public Health Council and consolidation of districts suggested from time to time when in the interest of efficiency and economy.*

5. *That the so-called "exemption" practice be discontinued.*

6. *That a new State Laboratory be constructed and the present Department of Agriculture Laboratory at Reynoldsburg be discontinued.*

This latter recommendation suggested the new laboratory be built as a wing to one of the laboratory buildings on the Ohio State University campus and planned so as to take care of all bacteriological and parasitological services provided by the State Government, all serological services, all chemical services, and the manufacture of biologicals, including tuberculin.

The report stated that "among the laboratory activities not now provided, for which the Department of Health should be responsible, are the following:

"Histo-pathological examination of suspected malignant growths (cancer).

"Toxicological examinations in case of suspected poisoning."

7. *That certain public health activities be transferred to the Department of Health, namely:*

(a) Functions now being performed by the Division of Foods and Dairies, Department of Agriculture.

(b) Function of hotel and restaurant inspection now being performed by the State Fire Marshal, Department of Commerce.

The report pointed out that the cost of operating the Department if the recommendations are put into effect would be $394,822, compared to the 1935 appropriation of $401,710.50.

STATE MEDICAL BOARD PRAISED

Prefacing its recommendations concerning the State Medical Board with the statement that "the operation of this long-established board is generally satisfactory and it should be continued as an independent board of licensure", the Committee pointed out that its inspection force is insufficient, the office equipment inadequate, and legislative action is necessary to make the Board's work more effective.

The following recommendations were made:

"1. *Increase in the field inspection staff from two to three at an annual increased expense of $3,000.*

"2. *Replace the present filing cases with labeled, fireproof, and drop-proof filing safes; also modernize the other office equipment.*

"3. *Amend Section 1262 of the Medical Practice Act by deleting the words "but no school shall have a majority of the board."*

"This is not now in conformity with the preceding clause providing for proportional representation," the report declared.

"4. *Amend the Medical Practice Act to make mandatory the maintenance of standards for pre-medical education comparable with the better standards established in other states."*

"Senate Bill No. 137 (91st General Assembly) will accomplish this purpose," the report stated.

The bill referred to would require by statute that all applicants to take the examinations given by the State Medical Board must present a certificate of having satisfactorily completed at least two full college years in pre-medical subjects at an accredited college or university.

"5. *Amend Section 12699 to provide, in connection with prosecutions, that fines collected shall be paid one-half to the Board and one-half to the General Revenue fund of the county in which the prosecution takes place. The entire amount at present is paid to the Board."*

STUDY OF OTHER LICENSING BOARDS

Recommendations affecting several other licensing boards were made in the report that covered independent state boards.

It was suggested that the efficiency of the State Dental Board could be improved if its policies were more clearly defined in connection with the Board's inspection activities and its relation to the dental profession.

No recommendations were made concerning the State Board of Pharmacy. The report stated that Board is operated effectively and economically and the public interest is well served.

The State Board of Optometry was criticised for inefficiency apparently due to faulty organization. It was recommended that a full-time inspector be employed, instead of having the inspections made by Board members on a per-diem basis; also that the Board establish its office in Columbus, as provided by law.

The Committee urged the abolishment of the State Board of Cosmetology. The report stated that the work represents an exaggerated program entirely out of proportion to the needs of public health, and the activities of the Board which are essential to the public health are more properly the responsibility of local health authorities.

Abolishment of the State Board of Barber Examiners also was recommended for essentially the same reasons.

INDUSTRIAL COMMISSION ISSUES STATEMENT SUMMARIZING STATUS OF FUND AND ITS ADMINISTRATIVE PROBLEMS

THOSE who read the article on pages 704-7 of the September issue of *The Journal*, outlining the recommendations made by the Ohio Government Survey Committee concerning the State Industrial Commission and the Workmen's Compensation Law, and who have been following newspaper comment of the report of that Committee and also the activities of the State Senate Workmen's Compensation Investigating Committee, will be interested in the following excerpts from a statement recently issued by the State Industrial Commission, calling attention to the administrative problems of the Commission and the present sound condition of the Workmen's Compensation Fund:

"Much of the misconception abroad in the state regarding the State Insurance Fund and the administration of workmen's compensation," the statement declared, "could be eliminated if the general public, employers and employes and the news commentators would recognize the fact that the Fund was established to be maintained and operated on insurance principles.

"The only guarantee offered to workers generally and to injured workers and the dependents of killed workers for injuries occasioned in the course of employment, that compensation and death benefits will be paid within the provisions of the Workmen's Compensation Law, is the stability of the Fund.

"As result of an investigation made by an internationally recognized authority on actuarial procedure, who was selected by a joint committee of employers and employes and the State Government, the report in referring to the record of the Fund stated that the Ohio Fund ranked high in comparison with other compensation systems, and also approved the rating plan.

FUND IS FULLY SOLVENT

"Within recent months a committee composed of representatives of employers, labor and the general public, appointed by Governor White, and the Sherrill Committee, have completed investigations and reported the Fund fully solvent, despite the fact that in the years 1930, 1931, 1932 and 1933 disbursements to claimants and for medical and hospital care exceeded by approximately $17,000,000 the contributions made by employers in those years.

"The Industrial Commission appreciates the fact that a personnel wholly inadequate in comparison with the Fund to be administered and the volume of work that the administration involves has made it impossible to give that degree of efficiency which would be assured if it were more fully manned and equipped. But even under these conditions, it challenges comparison with any similar state board in the expediting of the consideration of claims and the personal interest displayed towards applicants for compensation who have meritorious claims.

"There are two impressions abroad in Ohio, both of which have been given stimulus by criticism not based upon complete facts, which have a tendency to undermine the stability of the Fund, create discontent among claimants and arouse unjust suspicions in the minds of employers whose contributions create it.

MUST NOT BE "GRAB BAG"

"One is that the Fund should be a grab bag instead of a sound financial structure, that all claims should be allowed upon presentation and without investigation as to their merits, that provisions for the protection of injured workers and their dependents over a long period of years is unnecessary and that essential legal reserves for this purpose should be dissipated in reckless disbursements and the establishment of ruinously low premium rates.

"The other is that a fund which has frequently withstood the closest scrutiny of actuarial experts should be so manipulated that special concessions are made to favored employers.

"Both of these impressions are equally ridiculous and indicate to what extent the public judgment can be influenced by criticism not fully supported by facts.

"Apparently it has never occurred to those who are willing to subscribe to charges of inefficiency in the administration of the Fund that any private insurance company operating a $40,000,000 fund would not think of attempting to give its clients effective service with less than three times the personnel of the Industrial Commission and an overhead charge of at least three times the appropriation set aside for the administration of the State Fund.

COMPARED TO INSURANCE COMPANIES

"The Commission realizes that no institution of the magnitude of the State Insurance Fund can be operated to the complete satisfaction of all elements, but it does contend and feels assured that an impartial analysis of the Fund will disclose its effectiveness in spite of the handicaps which it has experienced by reason of inadequate appropriations and the consequent lack of man power. Notwithstanding such handicaps, the Fund is fully solvent and has assured justice to every worthy claimant.

"Private insurance carriers of workmen's compensation insurance risks expend for operating purposes a sum equal to approximately 40 per

cent of the premium collected, while the annual allowances for operating purposes to the Ohio State Insurance Fund have been in amounts equal to less than 8 per cent of the contributions to the Fund.

"Notwithstanding the many handicaps, due to the lack of adequate personnel and facilities which have prevented the Commission from performing the work as efficiently as it desired, the Fund is solvent and the injured workmen and the dependents of workmen who have died by reason of injuries, are enjoying benefits by way of compensation and medical and hospital service equal to or in excess of that provided by many other states.

WORK OF DIVISIONS SUMMARIZED

"During the fiscal year ending June 30, 1935, the Claims Section, with only 77 employes, handled 155,411 claims, an average of 12,708 per month, in addition to 65,232 subsequent hearings held by the examining sections, 37,958 claims referred to and heard by referees or the Commission on special hearings, making a total of 258,601 hearings for the year, with an average time of six days per claim to clear the section.

"The Auditing Division, with only 55 employes, issued an average of 36,212 warrants per month, collected premiums from 40,332 private employers in addition to the premiums of employes of the state and its sub-divisions. In addition thereto, it collected maturing bonds and interest on bond investments in the approximate amount of $4,500,000 and reinvested a similar amount. The average time required for the issuance of a warrant after receipt of the claim sheet was three days.

"The Legal Section, with 70 employes, adjudicated 14,225 claims which would ordinarily go to the Commission, prepared statements of fact on 9,076 claims, filed 2,070 rehearings and disposed of 1,392 rehearings. Hearings held on rehearing claims numbered 1,442. Fifty thousand pages of testimony were transcribed. In addition, the section handled 436 Common Pleas Court cases, 48 Court of Appeals cases and 17 Supreme Court cases. The claims investigators handled 8,593 cases.

"The field auditors, a group composed of 25 men giving the major portion of their time to the work, completed 26,445 payroll audits and made additions to payrolls for premium purposes of $3,149,578.42. The special staff working in Cuyahoga County made one hundred audits and added $10,500,000 in payrolls, making a total of payroll additions of $13,649,572.42.

MEDICAL ACTIVITY REVEALED

"The Medical Section, with 28 employes, 15 of whom are physicians, made 15,879 physical examinations, of which 9,762 were outside of Columbus, an average of 1,157 per month, made and approved 185 hospital contracts, made 354 hospital visits, 47 home calls and 14 special trips to contact doctors and patients. The section averages 220 claims daily for approval medically as to compensation, hospital and medical fee bills.

"The Actuarial Section, with only 45 employes, established premium rates for the various industrial classifications, handled new applications for coverage, individually rated over 40,000 employers annually, conducted annual examinations of self-insurers, maintained payroll, premium and claim cost records, enforced compliance on non-complying employers, made special investigations and audits. During the year it handled 5,861 new applications for coverage, 1,055 reinstatements, 959 rating inspections, handled 155,411 new claims for assignment of classification and verification of coverage and applied individual rates to 41,334 employers twice during the year.

"These facts should convince any unprejudiced observer that the Industrial Commission is an active institution and that its methods are not as archaic as some would have the public believe."



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COUNTY SOCIETIES *and* ACADEMIES

First District

ACADEMY OF MEDICINE OF CINCINNATI
(H. J. Lavender, M.D., Secretary)

Officers of the Cincinnati Academy of Medicine for the ensuing year were installed at the first meeting of the Fall season, Monday, September 30. Addresses were made by Dr. John A. Caldwell, retiring president, and Dr. Edward D. King, incoming president. The regular meeting time of the Academy has been changed from Monday to each Tuesday at 8:15 P. M.—Bulletin.

Adams County Medical Society met at Mineral Springs, Wednesday, August 21. Dr. O. T. Sproull, West Union, spoke on "Peritoneal Effusions". Dr. A. L. Test, Portsmouth, presented a paper on "Gallbladder Disease Complicated by Pregnancy". Dr. Parke G. Smith, Cincinnati, councilor for the first district, discussed "Organization Problems". —News Clipping.

Warren County Medical Society held a meeting Tuesday, September 3, at Harmon Hall, Lebanon. Dr. Otto J. Seibert, Cincinnati, discussed thyroid conditions.—News Clipping.

Second District

Greene County Medical Society meeting at Xenia, Thursday, September 5, was addressed by Dr. C. A. Coleman, Dayton, on "Recent Advances in the Treatment of Kidney Diseases Including Nephritis".—Reyburn McClellan, M.D., Secretary.

Miami County Medical Society had the first of a series of Fall meetings at Stouder Hospital, Troy, Friday afternoon, September 6. Dr. E. C. Fischbein, Dayton, presented a paper on "Traumatic Neuroses".—G. A. Woodhouse, M.D., Secretary.

Third District

Marion Academy of Medicine met at the Marion City Hospital, Wednesday, September 4. The guest speaker was Dr. Walter M. Simpson, Dayton. He talked on "Artificial Fever Therapy", illustrated with two reels of motion pictures. At the request of the audience, Dr. Simpson also showed pictures taken by him in Yucatan last year. Guests included nurses, dentists and pharmacists of Marion and vicinity.—News Clipping.

Hancock County Medical Society met at the Elks' Club, Findlay, Thursday, September 5. Dr. F. W. Morley, Toledo, spoke on "Infant Feeding", and Dr. L. J. Herold, Toledo, discussed "Treatment of Hemorrhoids".—News Clipping.

Fourth District

Putnam County Medical Society met Tuesday evening, September 10, at the Methodist church in Pandora for a dinner program. Dr. N. W. Gillette, Toledo, discussed "Thyroid".—News Clipping.

Fifth District

ACADEMY OF MEDICINE OF CLEVELAND
(Justin A. Garvin, M.D., Secretary)

The annual golf tournament and field day of the Cleveland Academy of Medicine was held at the Oakwood Country Club, Wednesday, September 4.

At the regular meeting of the Academy, Friday, September 20, Dr. Ralph H. Major, Kansas City, Missouri, discussed "Medical Aspects of Arterial Hypertension", and Dr. Max Peet, Professor of Neuro-Surgery, University of Michigan, talked on "Surgical Aspects of Hypertension".

Ashtabula County Medical Society held its annual picnic Thursday, August 15, at the Ashtabula Country Club, with lawyers, dentists and pharmacists of the county as guests.—News Clipping.

Sixth District

Mahoning County Medical Society opened its Fall program with a meeting, Tuesday, September

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Prompt and Full Report

17, at the Youngstown Club. Dr. Everett D. Plass, professor of obstetrics, University of Iowa, spoke on "Simplification of Obstetric Care".—News Clipping.

Portage County Medical Society met at the Robinson Memorial Hospital, Ravenna, Thursday, September 5. Dr. Walter A. Hoyt, Akron, discussed, "Head Injuries in Automobile Accidents, with Special Reference to Skull Fractures".—E. J. Widdecombe, M.D., Secretary.

Stark County Medical Society met at the Elk's Club, Canton, Thursday evening, September 12. Dr. H. W. Gauchat, Canton, spoke on "Some Clinical Observations in Disorders of the Heart Beat", illustrated by lantern slides. The subject also was discussed by Dr. D. D. Shontz, Massillon.—H. W. Beck, M.D., Secretary.

Summit County Medical Society held a meeting Tuesday, September 5, at the Mayflower Hotel, Akron. Dr. Philip H. Kreuscher, assistant professor of Surgery, Northwestern University, Chicago, delivered an address on "Back Injuries and Inflammations".—Bulletin.

Eighth District

Guernsey County Medical Society met at the Berwick Hotel, Cambridge, Thursday, September 5. Dr. M. S. Lawrence, Quaker City, spoke on the duties of public health officers.—News Clipping.

Muskingum County Academy of Medicine met at the Hotel Rogge, Zanesville, Wednesday, September 5. Dr. W. A. Melick spoke on the recent cruise of the Pan-American Medical Association to South America. Charles S. Nelson, Columbus, Executive Secretary, Ohio State Medical Association, discussed proposed legislation of interest to physicians, other activities of the State Association, and the functions of the State Headquarters Office.—Beatrice Hagen, M.D., Secretary.

Ninth District

Scioto County—The annual golf tournament of the Hempstead Academy of Medicine was held at the Raven Rock Country Club, Portsmouth, Thursday, September 5.—Wm. E. Scaggs, M.D., Secretary.

Tenth District

COLUMBUS ACADEMY OF MEDICINE

(Drew L. Davies, M.D., Secretary)

September 23—"Symposium on Skin Diseases". Dr. Charles J. Shepard, "Case Report and Demonstration"; Dr. L. L. Praver, "A New Practical Approach to Some of the Common Skin Diseases"; Dr. H. M. Platter, "Acne Rosacea".

September 30—"Recent Studies on Surgical Lesions of the Stomach and Duodenum", by Dr. Waltman Walters, associate professor of surgery, University of Minnesota and consulting surgeon at the Mayo Clinic.

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BLOOD CHEMISTRY
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PEDIATRICS—Informal Course; Personal Courses.

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DEATHS IN OHIO

Byron Webster Beatty, M.D., Dayton; Ohio Medical University, Columbus, 1905; aged 52; member of the Ohio State Medical Association, Fellow of the American Medical Association, and member of the Clinical Orthopedic Society; died September 15. Dr. Beatty was one of the founders of Good Samaritan Hospital, Dayton, his gift of five acres of land actually starting the movement for the new hospital in 1928. He was first president of the Dayton Lions Club, and was prominent in that organization as well as the Masonic order. He was a member of the surgical staff at St. Elizabeth's Hospital, and was the first president of the Good Samaritan staff, a post which he held until last January when he was made a member of the executive board. Surviving are his widow, two daughters and a son.

Charles F. Culley, M.D., Cleves; Eclectic Medical College, Cincinnati, 1918; aged 42; died September 2. Dr. Culley was a member of the Masonic Order, Elks and Knights of Pythias. He practiced in Cleves for 17 years. Surviving are his widow, two adopted sons, four brothers, including Dr. Walter Culley, Bethel and Dr. Raymond Culley, Ashland, Ohio, and two sisters.

Frank M. Harrison, M.D., Napoleon; Jefferson Medical College, Philadelphia, Pa., 1896; aged 65; member of the Ohio State Medical Association and the American Medical Association; died August 21, following a year's illness from cancer. Dr. Harrison was secretary of the Henry County Medical Society for many years, and former president. He is survived by his widow, two daughters, and two brothers, Drs. Charles M. Harrison and Julian J. Harrison.

Max Dreyfoos, M.D., Cincinnati; Medical College of Ohio, Cincinnati, 1902; aged 58; member of the Ohio State Medical Association and Fellow of the American Medical Association; died September 3. Dr. Dreyfoos was director of the Rachford Memorial, treasurer of the Babies' Milk Fund, on the staff of Jewish Hospital, and until his resignation two years ago, assistant professor of pediatrics, College of Medicine, University of Cincinnati. Surviving are his widow and two daughters.

William Drake Hamilton, M.D., Columbus; Columbus Medical College, 1883; aged 76; member of the American College of Surgeons; former member of the Ohio State Medical Association and the American Medical Association; died August 23, at Cape Cod, Mass., from heart disease. Dr. Hamilton had been in ill health for many years, and retired from active practice in 1921. He and his brother, Dr. Charles S. Hamilton, with their father, the late Dr. John William Hamilton, founded Mt. Carmel hospital, Columbus. He was a member of the First Congregational Church. Surviving are his widow, a daughter and two brothers.

William J. Hughes, M.D., Moscow; Kentucky School of Medicine, Louisville, Ky., 1890; aged 74; former member of the Ohio State Medical Association and the American Medical Association; died August 11, after a long illness. Dr. Hughes practiced in Moscow for 40 years, and was active in the Clermont County Medical Society until his retirement in 1933. He was a prominent Mason and member of the local school board. He is survived by his widow.

George H. Musekamp, Sr., M.D., Cheviot; Medical College of Ohio, Cincinnati, 1884; aged 72; died September 2, following a heart attack. Dr. Musekamp had practiced in Cincinnati for many years. He is survived by a son and a daughter.

Frank S. Rarey, M.D., Columbus; Starling Medical College, Columbus, 1892; aged 80; member of the Ohio State Medical Association and Fellow of the American Medical Association; died September 7, following a week's illness. Dr. Rarey had lived in Franklin County all his life. He was a member of the Masonic order, Groveport Lodge of Elks and the First M. E. Church. Surviving are his widow and two sons.

Murray E. Swinehart, M.D., Columbus; Starling Medical College, Columbus, 1906; aged 59, member of the Ohio State Medical Association and Fellow of the American Medical Association; died September 9, after a year's illness from anemia. He is survived by his widow, four brothers and five sisters.

Edward J. Wilson, M.D., Columbus; Long Island College of Medicine, Brooklyn, N. Y., 1879; aged 79; former member of the Ohio State Medical Association and the American Medical Association; died August 29, following an illness of two years. Dr. Wilson retired five years ago. He was vice-president and medical director-emeritus of the Midland Mutual Life Insurance Company, and a member of the Masonic order. Surviving are three sons, including Dr. Philip D. Wilson, New York City and Dr. Edward Harlan Wilson, Columbus.

Theodore Winfield Workman, M.D., Akron; Medical College of Ohio, Cincinnati, 1879; aged 80; former member of the Ohio State Medical Association and the American Medical Association; died September 1, following a paralytic stroke. Dr. Workman retired from active practice several years ago. He was a member of the Masonic Order at Danville, and a former district deputy of the Knights of Pythias. He is survived by his widow and a son.

Chemistry Challenges Custom!

INFANT FEEDING advanced with the advent of mixed sugars in artificial formulae. But milk modifiers are more costly than milk. And mothers believe the mixed sugars to be the more essential constituents of the formula. The cost of the milk modifiers is kept high to keep up this delusion.

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Prescribe Karo, the modern milk modifier. Karo Syrup is essentially Dextrins, Maltose and Dextrose, with a small percentage of Sucrose added for flavor. It is the carbohydrate of choice because it is well tolerated, readily digested, effectively utilized. Karo does not cloy the appetite, produce fermentation or disturb digestion.

Corn Products Consulting Service for Physicians is available for further clinical information regarding Karo. Please Address: Corn Products Sales Company, Dept. SJ-9, *17 Battery Place, New York City.*

Seventh Annual Training Course Oct. 6-20 For Medical Reservists at Mayo Clinic

The two weeks' period, October 6 to 20, 1935, has been selected for the Seventh Annual Training Course for Medical Department Reservists of the United States Army and Navy, at the Mayo Clinic, Rochester, Minnesota.

These training courses at the Mayo Clinic were inaugurated by the Seventh Corps Area to give military training to the young Medical Corps Reserve Officers on the staff of that institution, who could not attend summer camps. It developed that reservists not connected with the clinic desired to attend. It was noted that inasmuch as the military work was given in the afternoon and evening hours, these men were able to attend the strictly professional presentations by the staff of the Mayo Clinic during the morning hours. In recent years, special professional presentations have been arranged as a regular part of the course.

The program will follow the plan which has been so successful in past years. The morning hours will be devoted entirely to professional work in special clinics and study groups. Officers in attendance may select the course they wish to follow from the wide variety of presentations offered. The afternoons and evenings will be devoted to medico-military subjects.

The staff and faculty of the Mayo Clinic will present the professional training, while the medico-military program will be under the direction of the Surgeon of the Seventh Corps Area (Army) and the Surgeon of the Ninth Naval District (Navy).

Enrollment is open to all Army and Navy reservists of medical departments, in good standing. Applications should be submitted to the Surgeon, Seventh Corps Area, Omaha, Nebraska, or the Surgeon, Ninth Naval District, Great Lakes, Illinois. Enrollment is limited to two hundred.

The Surgeon Generals of the Army, the Navy and the Public Health Service have all signified their desire and intention of being present during at least a portion of the course.

— OSMJ —

—Frank T. Hines, Veterans Administrator, recently announced the allotment of $600,000 for improvements to the veteran's hospital at Chillicothe, and $1,210,000 for the Dayton veteran's hospital.

— OSMJ —

—On August 13, the voters of Lawrence County approved a $145,000 bond issue for the erection of a county hospital at Ironton.





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A recent survey of prescription prices made by us reveals the fact that a prescription for BENZEDRINE SOLUTION (1 fl. oz.) costs approximately half as much as a similar prescription for ephedrine.

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In reporting a comparative study of the two, Scarano wrote:

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(*Med. Record: Dec. 5, 1934*)

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Well-Attended Meeting Held by Seventh District at the Belmont Hills Country Club

The annual meeting of the Seventh District of the Ohio State Medical Association was held at the Belmont Hills Country Club, Bellaire, Thursday, September 5. The event was well attended.

The morning was devoted to golf, while in the afternoon a business session was held. Dr. Guy Byers, Salem, president of the district, presided, with Dr. Stewart Harris, Elizabeth, as secretary.

The afternoon speakers were Dr. Louis J. Karnosh, Cleveland, who discussed "Studies of Patients Following Extensive Ablations of the Brain Tissue", and Dr. Lynden Holt Landon, Pittsburgh, who spoke on "The Gastric Ulcer Cancer Problem".

The principal speakers at the annual dinner of the organization were Dr. J. H. J. Upham, Columbus, Dean of the College of Medicine, Ohio State University, and chairman of the Committee on Public Policy of the State Association, who discussed "Medical Viewpoints on Modern Trends in Practice"; and Francis Wallace, novelist and sports-writer for the New York World-Telegram, who talked on "A Sports Forecast".

Following the dinner, dancing and bridge were enjoyed.

The highly successful meeting was planned by a general committee composed of Dr. C. W. Kirkland, Bellaire, councilor for the Seventh District, Dr. R. H. Wilson and Dr. F. P. Sutherland, Martins Ferry.

The program committee consisted of Dr. Miles Garrison and Dr. J. B. Martin, St. Clairsville; Dr. D. M. Creamer, Bellaire, and Dr. Sutherland and Dr. W. L. Davis, Martins Ferry.

—OSMJ—

Collections of Detroit Medical Bureau Exceed $100,000

Ohio physicians will be interested in the progress of the plan inaugurated by the Wayne County Medical Society, Detroit, Mich., for supplying medical service to the small-wage earner on a time-payment basis. The plan was analyzed in the March issue of *The Journal.*

In seventeen months of operation, the Detroit Medical Service Bureau collected (to August 23, 1935) a total of $100,954.29 from 2644 persons.

In the bureau's first month of operation a total of $85.00 was collected; the next month $636.00; the next $1,090.60, and so on until a peak of $10,104.57 for one month was reached after 15 months.

—OSMJ—

Cleveland—Dr. John B. Morgan is in Europe taking post graduate work in urology. He will return about January 1.

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Dramatized Radio Programs Sponsored By the A.M.A. Will Go On Air in October Over Blue Network

The toast "Your health, ladies and gentlemen", will introduce the new radio program of the American Medical Association which will be broadcast over the Blue Network of the National Broadcasting Company every Tuesday at 5:00 P. M., Eastern Standard Time, beginning October 1.

With the cooperation of the National Broadcasting Company a new type of program, in vivid dramatic form, with incidental music, is being developed, and will be presented under the general theme of "Medical Emergencies and How They Are Met".

The theme of the program will be repeated each week in the opening announcement, which informs the listener that the same medical knowledge and the same doctors that are mobilized for the meeting of grave medical emergencies, are available in every community, day and night, for the promotion of the health of the people. Each program will include a brief talk dealing with the central theme of the individual broadcast.

The October schedule is as follows:

October 1	**Burns, Morris Fishbein, M.D.**
October 8	**Hazards from Foreign Shores, W. W. Bauer, M.D.**
October 15	**Unconsciousness, Morris Fishbein, M.D.**
October 22	**Asphyxiation, W. W. Bauer, M.D.**
October 29	**To be announced.**

The Blue Network of the National Broadcasting Company comprises the following stations: WJZ, WSYR, KDKA, WCKY, WENR, WIBA, KSTP, WEBC, KFYR, KWCR, WREN, KWK, KSO, WBAL, WMAL, WTAR, WPTF, WWNC, WSOC, WIS, WSM, WMC, WJDX, KVOO, WKY, WFAA, KTBS, WOAI.

It is suggested that Ohio physicians post notices in their offices telling about this radio program for the information of their patients and otherwise promote this meritorious project by the A. M. A.

—OSMJ—

Youngstown—The annual reunion of former interns and resident physicians of the Youngstown Hospital was held at the Youngstown Country Club, August 22. About 125 physicians from the district attended the reunion, and elected Dr. H. E. Patrick, President for 1936; Dr. R. R. Morrall, vice-president, and Dr. John Noll, secretary.

CLASSIFIED ADVERTISEMENTS

Rates for advertisements under this heading are 50 cents per line, payable in advance. Minimum charge of $1.00 for each insertion. Price covers the cost of remailing answers. Forms close 16th of the month preceding publication.

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Both accepted by A. M. A.

Each flour is composed of wheat, soya, dextrose, corn starch, phosphate and soda. Kreemex Pancake contains wheat flour. Kreemex Buckwheat contains buckwheat and wheat flour.

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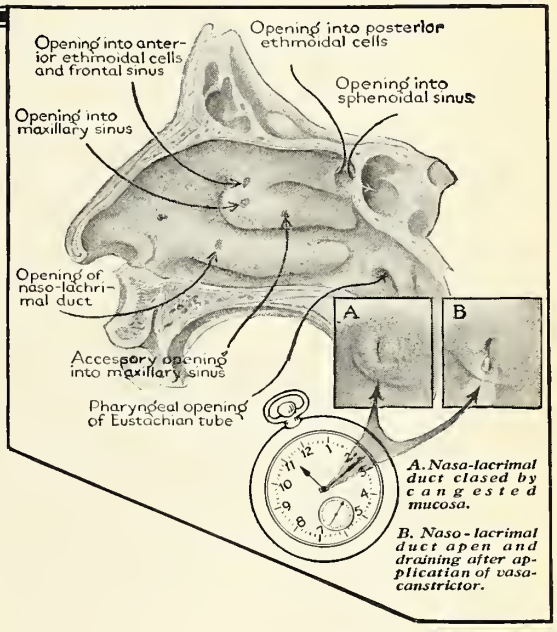
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NEWS NOTES *of* OHIO

Cincinnati—Announcement was recently made of the marriage of Dr. Samuel L. Bauer and Miss Beatrice Langhorst. Dr. Bauer is assistant professor of pediatrics at the University of Cincinnati and Miss Langhorst is one of the supervising nurses at the Children's Hospital.

Waynesville—Dr. J. E. Witham suffered a fractured hip in a fall at his home.

Cleveland—Dr. William F. Hulse, chief resident in ear, nose and throat at City Hospital in 1933 and 1934, was recently appointed chief of ear, nose and throat treatment at Sunny Acres, the city's tuberculosis sanatorium at Warrensville.

Columbus—Dr. Wayne Brehm was elected commander of the Upper Arlington Post of the American Legion.

Columbus—The residents of the Convent of the Good Shepherd recently gave a special program in honor of the birthday of Dr. Hervey W. Whitaker, physician for the institution.

Newark—Dr. James F. Busby, Detroit, has succeeded Dr. D. E. Yochem as superintendent of the Licking County tuberculosis sanatorium. Dr. Yochem has returned to Columbus to resume private practice.

Shelby—Dr. J. A. Ellery has become associated with Dr. M. T. Love in the practice of medicine here.

Columbus—The Medical Review Club has elected Dr. C. A. Hyer, president, and Dr. E. J. Stedem, secretary, for the coming year.

Akron—The tenth season of the Doctors Symphony Orchestra opened this month. Dr. A. S. McCormick continues as director.

Columbus—The following officers were recently elected by the Medical Forum for the coming year: Dr. H. H. Yoakem, president; Dr. W. Reinhard, vice-presdient, and Dr. John Edwin Brown, Jr., secretary and treasurer.

Logan—Announcement is made of the marriage of Dr. Victor A. Simiele and Miss Mary Madolyn Foley, Columbus.

Louisville—Dr. and Mrs. Ian B. Hamilton, recently sailed for London, England, where Dr. Hamilton will take post-graduate work for two months.

Martins Ferry—Dr. Harry E. Wilson, of Port Orchard, near Seattle, Washington, who formerly practiced here, recently visited his brother, Dr. Richard H. Wilson.

Youngstown—Dr. H. E. Blott recently celebrated his 47th anniversary as a physician and surgeon in this city. Dr. Blott has been ill for several months but is now recovering.



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REFINED DIPHTHERIA TOXOID (HIXSON) ALUM PRECIPITATED. The Toxoid that confers the highest degree of immunity with one injection.

DIPHTHERIA TOXIN (HIXSON) SCHICK TEST —DILUTED READY FOR USE—for determining susceptibility to Diphtheria. Our Schick Test Toxin is diluted in a chemical buffer solution, which insures its stability and freedom from excessive amounts of peptones.

DIPHTHERIA TOXIN ANTITOXIN MIXTURE—
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Readily ASSIMILABLE FAT -- an essential in FEEDING THE PREMATURE

IN a recent study of fat metabolism in infants, Holt, Tidwell and Kirk* report that olive oil showed the highest percent retention (95.1%) of all fats studied but one, olein (97.5%). These authors found the fat of SIMILAC (which is 20% olive oil) showed a better percent retention (92.6%) than butter fat (88.9%)—and as high a retention as breast milk fat (92.4%).

To quote these authors—"the differences in fat retention on these various fats as shown on normal infants are not great; for the normal infant it is probably immaterial whether he absorbs 85% or 95% of his fat intake. It seemed possible, however, that *in subjects who have difficulty in fat assimilation, such as premature infants, the observed small differences might become large differences. A few observations made on premature infants and twins have borne this out*—."

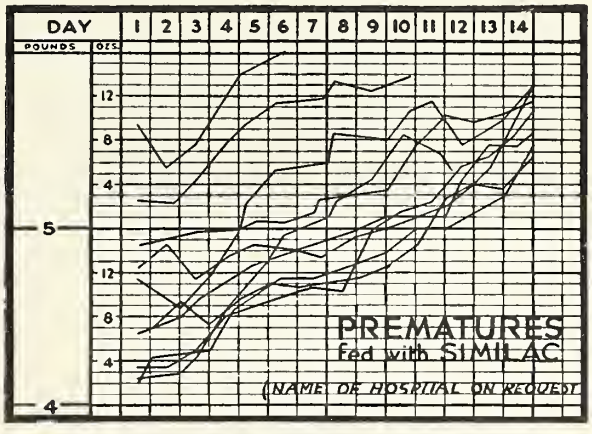
The observations referred to covered only three prematures fed on different fats, but showed an average of 78.4% retention for olive oil as compared to only 52.5% retention for butter fat.

*Holt, Tidwell and Kirk, Studies on Fat Metabolism in Infants—Acta Pediatrica. Vol. XVI, 1933.

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has given noticeably good results in feeding the premature infant. One of the reasons lies, as here pointed out, in the composition of its fat. Another reason is its consistently zero curd tension. The finer the curd the greater the surface area. The greater the surface area the more exposed are the fats, carbohydrates, proteins and salts to the digestive enzymes. Result . . . the food substances are more quickly and readily utilized.

SIMILAC is made from fresh skim milk (casein modified) with added lactose, salts, milk fat, and vegetable and cod liver oils.



The fact that SIMILAC is well assimilated by the immature digestive tract of the premature indicates how entirely suitable it is for all those infants who are deprived of breast milk.

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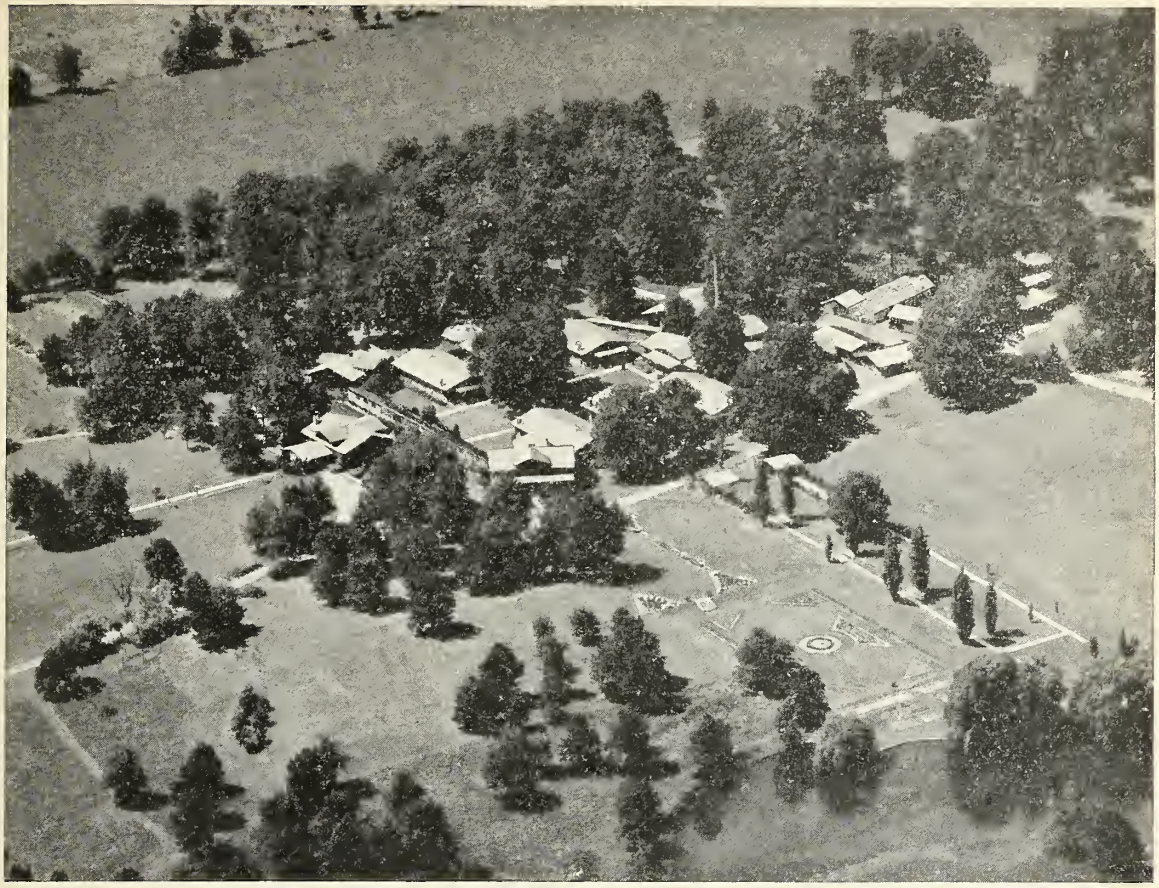
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First District			
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Brown	R. B. Hannah, Georgetown	Geo. P. Tyler, Jr., Ripley	4th Wednesday in Feb., May and Nov.
Butler	H. A. Moore, Oxford	V. E. Roden, Hamilton	2d Wednesday, monthly.
Clermont	Carl Minning, Williamsburg	J. M. Coleman, Loveland	3d Wednesday, monthly.
Clinton	A. C. Roberts, Wilmington	V. E. Hutchens, Wilmington	1st Tuesday, monthly.
Fayette	J. M. Harsha, Washington C.H.	J. F. Wilson, Washington C. H.	1st Thursday, quarterly.
Hamilton	Edw. D. King, Cincinnati	Donald J. Lyle, Cincinnati	Monday evening of each week.
Highland	H. H. Lowe, Leesburg	W. B. Roads, Hillsboro	1st Wednesday, monthly.
Warren	P. W. Tetrick, Mason	James Arnold, Lebanon	1st Tues. Apr., May, June, Sept., Oct., and Nov.
Second District			
Champaign	W. A. Yinger, Rosewood	F. E. Lowry, Urbana	2d Thursday, monthly.
Clark	C. S. Ramsey, Springfield	A. A. Gavey, Springfield	2d and 4th Thursday.
Darke	J. W. Van Lue, Gettysburg	W. D. Bishop, Greenville	3d Friday, monthly.
Greene	Geo. Davis, Xenia	R. R. McClellan, Xenia	1st Thursday, monthly.
Miami	E. G. Puterbaugh, Tippecanoe City	G. A. Woodhouse, Pleasant Hill	1st Friday, monthly, except July and August.
Montgomery	A. G. Farmer, Dayton	Miss M. E. Jeffrey, Dayton	1st & 3d Friday, Oct. to June
Preble	J. B. Lucas, West Alexandria	C. E. McKinley, Camden	3d Thursday, monthly.
Shelby	J. F. Conner, Sidney	H. C. Clayton, Sidney	1st Friday, monthly.
Third District			
Allen	W. A. Noble, Lima	H. C. Weisenberger, Lima	3d Tuesday, monthly.
Auglaize	E. F. Heffner, Wapakoneta	C. C. Berlin, Wapakoneta	2nd Thrusday, bi-monthly.
Hancock	H. O. Crosby, Findlay	R. S. Rilling, Findlay	1st Thrusday, monthly.
Hardin	F. M. Elliott, Ada	W. N. Mundy, Forest	3d Thursday, monthly.
Logan	C. K. Startzman, Bellefontaine	M. L. Pratt, Bellefontaine	1st Friday, monthly.
Marion	J. A. Dodd, Marion	F. D. Yeager, Marion	1st Tuesday, monthly.
Mercer	L. M. Otis, Celina	F. E. Ayers, Celina	2d Thursday, monthly.
Seneca	W. W. Lucas, Tiffin	R. E. Hershberger, Tiffin	3d Thursday, monthly.
Van Wert	B. L. Good, Van Wert	C. A. Morgan, Van Wert	1st Tuesday, monthly.
Wyandot	B. A. Maloney, Upper Sandusky	L. W. Naus, Upper Sandusky	1st Thursday, monthly.
Fourth District			
Defiance	P. B. Newcomb, Defiance	H. B. Wideman, Defiance	2nd Tuesday, Sept. to June
Fulton	C. F. Hartmann, Wauseon	Geo. McGuffin, Pettisville	3d Thursday, monthly.
Henry	C. G. Hissong, Hamler	F. M. Harrison, (dec'd) Napoleon	2nd Tuesday, monthly.
Lucas	T. L. Ramsey, Toledo	F. C. Clifford, Toledo	Friday, each week.
Ottawa	L. L. Belt Marblehead	Cyrus R. Wood, Port Clinton	2nd Thursday, monthly.
Paulding	K. C. Evans, Payne	F. A. McCammon, Payne	3d Wednesday, monthly.
Putnam	C. W. Bird, Continental	L. M. Piatt, Ottawa	1st Tuesday, monthly.
Sandusky	A. F. Schultz, Fremont	C. J. Wolf, Fremont	Last Thursday, monthly.
Williams	E. R. Jacka, Bryan	H. R. Mayberry, Bryan	2nd Thursday, monthly, Sept. to June.
Wood	F. L. Sterling, Bowling Green	R. N. Whitehead, Bowling Green	3d Thursday, monthly.
Fifth District			
Ashtabula	E. H. Merrell, Geneva	M. R. Martin, Geneva	2nd Tuesday, monthly.
Cuyahoga	Lester Taylor, Cleveland	J. A. Garvin, Cleveland	3d Fri., Feb., March, May, Sept., Nov., Dec.
Erie	L. S. Hill, Sandusky	R. M. Knoble, Sandusky	Last Thursday, monthly, except July, Aug.
Geauga	F. S. Basquin, Chardon	Isa Teed-Cramton, Burton	Last Wednesday, Apr. to Dec.
Huron	L. H. Hayhurst, Greenwich	C. B. Thomas, Greenwich	Once monthly, Feb., May, Sept. and Dec.
Lake	C. H. Browning, Painesville	Mabel Pearce, Painesville	Last Tuesday, monthly.
Lorain	L. H. Trufant, Oberlin	Zina Pitcher, Elyria	2nd Tuesday, monthly.
Medina	F. C. Reuter, Spencer	J. K. Durling, Wadsworth	3d Thursday, monthly.
Trumbull	M. T. Knappenberger, Warren	A. H. Seiple, Warren	2d Tues., monthly, Sept.-May.

Societies	President	Secretary	
Sixth District	R. S. Friedley, Akron	K. H. Harrington, Akron	2d Wed., Jan., April and Oct.
Ashland	L. G. Sheets, Ashland	M. J. Thomas, Jeromesville	2d Friday, Sept. to May
Holmes	Clyde Bahler, Walnut Creek	C. T. Bahler, Walnut Creek	1st Wed., Feb., Apr., June, Aug., Oct., Dec.
Mahoning	J. L. Fisher, Youngstown	W. M. Skipp, Youngstown	3d Tuesday, monthly.
Portage	A. M. Landsborough, Garrettsville	E. J. Widdecombe, Kent	1st Thursday, monthly.
Richland	B. E. Shreffler, Mansfield	H. C. Winbigler, Mansfield	Last Thursday, monthly.
Stark	M. E. Scott, Massillon	H. W. Beck, Canton	2d Tues., monthly, except July and Aug.
Summit	J. D. Smith, Akron	A. S. McCormick, Akron	1st Tuesday, monthly.
Wayne	W. A. Fritz, Wooster	R. C. Paul, Wooster	4th Friday, monthly.
Seventh District			
Belmont	W. L. Davis, Martins Ferry	C. W. Kirkland, Bellaire	1st Thurs., monthly, 4 p. m., except July and August.
Carroll	(With Stark Co. Society)		
Columbiana	F. R. Crowgey, Salem	G. E. Byers, Salem	2d Tuesday, monthly.
Coshocton	C. M. Neldon, Coshocton	J. D. Lower, Coshocton	4th Thurs., monthly.
Harrison	A. C. Grove, Jewett	W. C. Wallace, Hopedale	3d Wednesday, monthly.
Jefferson	W. H. Minor, Steubenville	J. Y. Bevan, Steubenville	3d Tuesday, monthly.
Monroe	G. W. Steward, Woodsfield (dec'd)	A. R. Burkhart, Woodsfield	2d Wednesday, monthly.
Tuscarawas	R. J. Foster, New Philadelphia	C. M. Dougherty, New Phila.	2d Thursday, monthly.
Eighth District			
Athens	W. E. Howe, Nelsonville	T. A. Copeland, Athens	1st Monday, monthly.
Fairfield	K. W. Taylor, Pickerington	C. W. Brown, Lancaster	2d Tuesday, monthly.
Guernsey	C. A. Craig, Cambridge	Reo Swan, Cambridge	1st and 3d Thursday each month.
Licking	Geraldine Crocker, Granville	G. A. Gressle, Newark	Last Friday, monthly.
Morgan	D. G. Ralston, McConnelsville	C. E. Northrup, McConnelsville	3d Tuesday, monthly.
Muskingum	W. D. Coffman, Zanesville	Beatrice C. Hagen, Zanesville	1st Wednesday, monthly.
Noble			
Perry	C. B. McDougal, New Lexington	F. J. Crosbie, New Lexington	3d Monday, monthly.
Washington	A. H. Smith, Marietta	R. M. Meredith, Marietta	2d Wednesday, monthly.
Ninth District			
Gallia	E. G. Lupton, Gallipolis	Milo Wilson, Gallipolis	1st Wed., Feb., May, Sept. and Dec.
Hocking	J. L. Webb, Nelsonville	M. H. Cherrington, Logan	2d Thursday, monthly.
Jackson	J. S. Hunter, Jackson	J. J. McClung, Jackson	2d Tuesday, monthly.
Lawrence	R. F. Massie, Ironton	W. W. Lynd, Ironton	1st Thursday, monthly.
Meigs	H. M. Crumley, Pomeroy	R. E. Boice, Middleport	3d Thursday, bi-monthly.
Pike	L. E. Wills, Waverly	R. T. Leever, Waverly	1st Monday, monthly.
Scioto	R. P. Elder, Portsmouth	Wm. E. Scaggs, Portsmouth	2d Monday, monthly.
Vinton	O. S. Cox, McArthur	H. D. Chamberlain, McArthur	3d Wednesday, monthly.
Tenth District			
Crawford	M. L. Helfrich, Galion	C. J. Griebling, Galion	1st Monday, monthly.
Delaware	J. K. James, Delaware	W. E. Borden, Delaware	1st Tuesday, monthly.
Franklin	E. G. Horton, Columbus	Drew Davies, Columbus	1st four Mondays, monthly.
Knox	E. V. Ackerman, Fredericktown	R. L. Eastman, Mt. Vernon	Last Thursday, monthly.
Madison	R. W. E. Irwin, Mt. Sterling	F. A. Lutz, Mt. Sterling	4th Wednesday, monthly.
Morrow	E. C. Sherman, Cardington	T. Caris, Mt. Gilead	Last Thursday, monthly.
Pickaway	R. S. Hosler, Ashville	E. R. Austin, Circleville	1st Friday, monthly.
Ross	O. P. Tatman, Chillicothe	W. C. Breth, Chillicothe	1st Thursday, monthly.
Union	P. D. Longbrake, Marysville	H. E. Stricker, Marysville	2d Tuesday, monthly.

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Vol. XXXI NOVEMBER, 1935 No. 11

AN APPRAISAL OF ORGANIZED MEDICINE IN OHIO

Annual Address of the Retiring President

By JOHN A. CALDWELL, M.D., CINCINNATI, OHIO

ONE hundred years ago there was held in Columbus the first meeting of physicians from different parts of the State of Ohio, gathered for the purpose of effecting a state-wide organization to promote the scientific and professional welfare of the members and to further their service to the public.

Among those present were the immortal Daniel Drake from Cincinnati and others who achieved local prominence in their communities. The program of this meeting reveals most impressively the changes which have taken place in the science of medicine, transportation, and medical education.

From an unorganized group representing no one but themselves, there has grown within the century one of the best organized, most representative state associations to be found in our Union. It includes approximately 85 per cent of the eligible practicing physicians of the state; publishes one of the best state medical journals, and gives professional news, medical economic service, and scientific information of the highest order for dues lower in comparison to the services rendered than any other state medical association. These things have all been made possible by the individuals who so unselfishly gave of their time and labors for the advancement of their profession, often at considerable personal sacrifice.

HEADQUARTERS OFFICE ESTABLISHED

In 1913 organization matters became too complex and numerous to be carried on by volunteer workers exclusively, and we acquired our first executive secretary, Mr. George V. Sheridan. After serving us most valuably for several years, he accepted a similar position with wider opportunities, but during his incumbency he took on and educated in the work Mr. Don K. Martin, who succeeded Mr. Sheridan when he retired.

Mr. Martin, while not a medical man, had a singularly clear understanding of medical ideals and purposes, the proper relation between physician and patient, and the value of scientific progress.

Much of the efficiency and success of the State Association in the measures which it has furthered is due to the efforts of Mr. Martin and the impression which he inspired for candor, clear thinking, and good judgment.

His efforts finally attracted such notice by others, that he was last March offered greater opportunities in a much wider but similar field, and left us with keenest regret on our part, but best wishes for his success and gratification at his recognition.

But he in turn had trained in his work, Mr. Charles S. Nelson, who has succeeded him, and promises to carry on with all of his understanding and no diminution of the usefulness of our State Headquarters Office to the members.

MUST HAVE AID OF MEMBERS

While there comes to my mind no words other than encomiums for our central office, let me call to your attention a serious danger in the tendency to leave solely to our State Headquarters Office and a few interested members, matters of importance to the profession. I refer to the inclination of many in the rank and file of our membership to become indifferent to organization work and its necessity; to the sense of false security

which is engendered by the feeling that the Headquarters Office can handle all problems, promptly, easily, wisely and satisfactorily. Our Headquarters Office has been efficient and effective in most instances in the past. However, its usefulness could have been greater had it had more complete cooperation and aid of the county society officers and members. Without this your Headquarters Office goes into battle without adequate equipment and short of ammunition.

SELF-EDUCATION AND PUBLIC CONTACTS

On the wall of our Headquarters Office hangs a picture of Theodore Roosevelt, and under it a quotation from one of his addresses, namely: "Every man owes some of his time to the upbuilding of the profession to which he belongs".

I would suggest that this quotation might be worked into the cover design of our *Journal* where it would probably cause some members to inquire of themselves how they could most effectively do this. Of course, first of all by discharging their full duty to their patients, and carrying out the traditional tenets of their calling. Next, by losing no chance to acquaint those with whom their practice brings them in contact that the medical profession is interested only in furthering the public good. Then, by making themselves familiar through the reports of the Council, committees, and individuals, as published in *The Journal*, and discussing at local meetings the questions there presented.

Where situations arise in communities, which are unusual or peculiar to that place, much aid can be secured from the accumulated information at our Columbus office, and the fullest assistance is always promptly available to any individual or society which requests it. I might mention as examples of how that office has been of the greatest assistance, matters dealing with the State Industrial Commission, the State Department of Welfare, the State Health Department, and the giving of advice and quoting of precedents in questions of discipline.

During the year, our Committee on Public Policy goes to great pains to acquaint members through their local societies with measures pending in the Legislature affecting medical practice or physicians. The contents of these bulletins should be discussed at society meetings, and the public should be informed as to our attitude toward such measures and reasons for it.

ORGANIZATION IS THOROUGHLY DEMOCRATIC

The comment is heard occasionally that the state medical society is run by a few individuals. Of course, in a certain sense that is true—not only of the Ohio State Medical Association but of every other group which aims to accomplish anything. In any voluntary organization whatever is done, comes about through the efforts and interest of those who want to see it done.

The constitutional set-up of our organization specifies that the administration of our affairs shall be handled by those selected by the membership for such responsibilities. This is correct organization procedure and is the only way any organization can accomplish its objectives. At the same time, those chosen for administrative positions must follow the will of the majority of the membership. In our Association this has been done. While it may not be possible for each member to have a major part in carrying out the plans of the organization, it is possible for him to use his voice and influence towards seeing that the measures it proposes are useful and worthy; that those selected to carry them out are well-qualified for the purpose; and give to them active assistance in administrative duties.

ACTIVITY OF THE COUNCIL

Much of the discussion which takes place in your Council is on two subjects.

First, how best to arouse and sustain interest and help on the part of the membership toward the accomplishment of the aims of the profession for the good of the public and individual physicians.

Second, how best to bring to the busy practitioner the improvements in practice, developments in science, and treatment. I have already suggested how the first of these should be met, and the only way in which I can see that it can be met.

For carrying out the second function, a committee of the Council has been considering a plan for the State Association to furnish speakers, well qualified in particular subjects, who would appear before societies who requested their services. Of course, there is the peril in such a scheme that requests for enlightenment will arise from inertia rather than from real desire to be informed—in which case, the speaker will render no real service. One never really relishes spoon-feeding, unless he is too weak to feed himself or is really hungry.

CHANGES IN CONSTITUTION SUGGESTED

In seeking the best means for the Council, officers and committees of the State Association to be of service to the profession, your Council and its committees have in some instances discovered lack of authority on the part of our Constitution and By-Laws, and in others, definite provisions in those instruments, which prevent the institution of some plans which were considered meritorious.

While our Constitution and By-Laws are in the main adequate and not complicated or hampering, there are some sections which can be simplified and made more elastic without disturbing the general plan with which we are familiar.

I would recommend to the incoming President that he appoint a committee of three to study the

Constitution and By-Laws, and suggest such revisions, deletions and additions as would tend to bring those instruments up to date, and help to make them more efficient for carrying out the aims and welfare of the organization.

In making this recommendation I am in no sense suggesting a general revision or redrafting of our organic law, but only such changes as are deemed necessary. Such committee would make its study during the coming year and make its report through *The Journal* in time to have its recommendations acted upon by the House of Delegates at the 1936 Annual Meeting.

SERIOUS PUBLIC HEALTH QUESTION

In the past few years there has been increasing attention given to a matter which has become a serious problem in public health. I refer to navigable stream polution. Ironical as it may seem, our large navigable streams serve the double purpose of sources of water supply to the communities living on their banks and on the banks of their tributaries, and also as the sewers for those same communities. As population multiplies, stream polution increases, and the value of the stream as a source of pure water supply as well as healthful recreation diminishes, till these former sources of beauty, health, and pleasure become sources of discomfort and ill-health.

It is well within the memory of most physicians when typhoid fever was a scourge as well as an index of the indifference of the public to its own welfare regarding public health. Because purification of water supply was expensive and caused some personal inconvenience, the warnings of physicians and sanitarians were for years unheeded and much unnecessary sickness and many deaths resulted from the disregard of constantly repeated demonstrations of neglect. When the move finally for improvement of water supply started, typhoid rapidly disappeared, so that it is now comparatively rare, but this was only brought about by elaborate means for filtration, expensive to install, and requiring costly and attentive watchfulness. A curious human trait, to devote so little attention to prevention and so much to correction—yet in social life we all recognize how much innocence is to be preferred to repentance.

The time is at hand when the Ohio State Medical Association should take some action looking toward the abatement of stream pollution. Since the efforts of one state acting without the cooperation of adjacent states is futile, this question is certainly one for federal control.

The United States Public Health Service has a high record for accomplishment and efficiency, and would be the appropriate branch of the government to control this situation.

The federal government prescribes rules for equitable and safe navigation of waters, forbids obstruction to navigation, cares for those employed on such waters, expends huge sums for improvement of channels, yet any one may so pollute a clear and beautiful stream by sewage or commercial waste as to change it from a clear and limpid health-giving thing of beauty into a noisome nuisance, and encounter no federal remonstrance.

I would suggest action by the House of Delegates to lend the influence of the Ohio State Medical Association to aid in any appropriate measures.

RELIEF; WORKMEN'S COMPENSATION PROBLEMS

In the past year, your Council, officers and committees have carried on continuous negotiations with two administrative bodies which have important relations with physicians. I refer to the Ohio office of the Federal Emergency Relief Administration and the State Industrial Commission. With the former, the problem has been so large, so varied in different communities, and has grown up so suddenly, that there has been much confusion, delay and consequent hardship both to medical men and, in some instances, those they were attempting to relieve.

The actions of the Council, and the many conferences between its committees and the executive secretary on one side, and the relief authorities on the other, have been fully reported in *The Journal*. To review these would cause this address to exceed reasonable limits and would add nothing. I would only state that the Committee on Public Policy and the executive secretary have kept in close touch with the relief authorities, and have done and are doing everything possible to bring some order, system, and promptness out of the chaotic situation.

RELIEF RESPONSIBILITY SHIFTING

At present it appears as if the relief problem rapidly is shifting to one of local responsibility and local initiative. It is the intention of the federal government to discontinue direct relief. It is doubtful if a state-wide program will be inaugurated. Therefore, the responsibility will fall on the shoulders of the local communities. Each community will be expected to establish its own relief program, including medical care of the poor. The county medical societies must take the lead in working out with local relief officials a medical program which will meet local needs and be satisfactory to members of the medical profession. The experiences of our Committee on Public Policy during the past two years should be of great value to the local societies and it is hoped they will call on it for advice on this important matter.

COOPERATION WITH INDUSTRIAL COMMISSION

Our dealings with the Industrial Commission have been friendly and cooperative. Some of the

reforms which we advocated have been adopted or promised, and more have been approved but will require legislative action before they can be put into effect.

In the recent legislative session the perennial efforts by various cults have been made to acquire further broadening of their privileges, to make them approach complete practice of medicine. These were successfully prevented due to the efficient efforts of your Committee on Public Policy, and your executive secretary, with excellent cooperation from representatives of the county societies.

THE PAST AND THE FUTURE

While the year has been full of vexations and unusual problems, it has been on the whole a successful one. Our membership has increased, unrest is gradually diminishing, and our profession seems well united on most major questions.

As with every one who has had the desire to aid the cause to which he is devoted, I become more and more conscious of my short-comings and lack of complete knowledge. I could wish to have accomplished more, to have established some record for definite achievement—but the time has been short, and in the past year our efforts have necessarily been directed to handle the immediate problems rather than to extend our activities.

For my successor I wish for a year free from vexatious distractions, fruitful in accomplishment for the future. Since he will have the same associates as I have had with some few changes, I can predict for him the utmost in cooperation, industry, interest in the cause and sane judgment.

—OSMJ—

Northwestern Ohio Picks Findlay For Its 1936 Annual Meeting

The 91st Annual Meeting of the Northwestern Ohio Medical Association was held at Marion, September 24.

Speakers at the afternoon session and the subjects discussed were: Dr. R. Franklin Carter, associate professor of surgery, Columbia University, "Appendicitis in Children"; Dr. William Gordon, Detroit, "Malignant Neutropenia"; and Dr. Henry Schmitz, Chicago, "Improvements in the Treatment of Cancer".

At a public meeting held in the evening, Dr. Morris Fishbein, editor of *The Journal of the American Medical Association*, spoke on "Medicine in the Changing Social World".

Findlay was selected as the meeting-place for next year, and the following officers were elected: Dr. E. E. Rakestraw, Findlay, president; Dr. J. M. Leahy, Tiffin, vice-president; Dr. A. S. Avery, Toledo, secretary, and Dr. E. L. Brady, Marion, treasurer.

Ohio State Alumni Invited to Fall Graduate Assembly, Nov. 16 On University Campus

The Fall Graduate Program of the College of Medicine, Ohio State University, will be held on the morning of November 16.

The program of clinics, lectures and demonstrations has been arranged by the Alumni Association with the cooperation of the faculty, so that returning physicians can attend the homecoming Ohio State-Illinois football game that afternoon.

The program is as follows:

MEDICAL CLINICS—UNIVERSITY HOSPITAL
9 a. m. to 11 a. m.

Research Medicine—1 B
Dr. G. W. Thorne—Adrenal Insufficiency
Dr. C. A. Doan—Eplastic Anemia
Dr. B. K. Wiseman—Lymphatic Luekemia
Dr. G. M. Curtis—Toxic Goiter

General Medicine—Lecture Room 2nd Floor
Dr. G. I. Nelson—Diabetes Mellitus
Dr. S. A. Hatfield—Subacute Bacterial Endocarditis
Dr. P. T. Knies—Chronic Non-tubercular Pulmonary Diseases
Dr. F. C. Wagenhals—Neurological Conference

Pediatrics Medicine—2 A
Dr. J. E. Brown, Jr.—Care of the Pre-Mature
Dr. E. H. Baxter—Problems in Infant Feeding
Dr. E. G. Horton—Contagious Diseases
(Transportation to and from Isolation Hospital provided)

SURGICAL CLINIC—UNIVERSITY HOSPITAL
8 a. m. to 11 a. m.

Dr. V. A. Dodd—General Surgical Clinics
Dr. G. M. Curtis—Splanchnic Resection & Thoracoplasty
Dr. J. W. Means—Common Diseases of the Breast
Dr. W. N. (Jack) Taylor—Genito Urinary Clinic
Dr. H. G. Beatty—Laryngology and Bronchoscopy
Dr. A. D. Frost—Operative Eye Clinic
Dr. P. J. Reel—Operative Gynecological Clinic
Dr. E. T. Kirkendall—Cancer Clinic
Dr. H. E. LeFever—Intrathecal Injection for Pain
Dr. Fred Fletcher—Operative Gynecological Clinic
Dr. Andrews Rogers—Obstetrical Clinic

JOINT MEETING—LECTURE ROOM 2ND FLOOR
11 a. m. to 11:30 a. m.

Dr. Harry Reinhart—Clinical Pathological Conference

Meeting of the Medical Alumni Association in charge of Dr. W. H. Martin, President, Dr. Jonathan Forman, Secretary, and J. B. Fullen, Exec. Sec'y. O. S. U. Alumni Association.

A cordial invitation is extended by Dr. J. H. J. Upham, dean of the College of Medicine, to all medical alumni and visiting physicians to attend this program as well as the clinics and pathological conferences held every Saturday at 11 o'clock at University Hosiptal.

Officers of the Medical College Alumni, elected at the 101st Anniversary and Post Collegiate Medical Assembly held in Columbus last March, are Dr. W. H. Martin, Detroit, Mich., president; Dr. Henry Lehrer, Sandusky, first vice-president; Dr. Ralph Holmes, Chillicothe, second vice-president, and Dr. Jonathan Forman, Columbus, secretary.

—OSMJ—

Cleveland—Dr. Walter G. Stern, Orthopaedic Surgeon to Mount Sinai and St. John's Hospitals, held a seminar for The Society of Industrial Physicians and Surgeons of West Virginia, at Charleston, West Va., on October 4. He read papers on "Conservative Treatment of Compound Fractures"; "Bumper Fractures of the Tibia and Fibula"; and "The Estimation of Disability from an Orthopaedic Standpoint".

ORGANIZED MEDICINE AND THE INDIVIDUAL PHYSICIAN

Inaugural Address of the Incoming President

By R. R. HENDERSHOTT, M.D., TIFFIN, OHIO

REALIZING because of the mandatory provisions of our Constitution and By-Laws, not because of any oratorical ability or physical charm on my part, I would be called upon at this occasion to say a few words, preliminary to assuming the responsibilities of the presidency of this great Association—an obligation and an honor which cannot be described by mere words—I must confess to having been the victim of neurasthenia and can easily sympathize with the adolescent youngster on the eve of his appearance on the annual class day program of the local high school.

However, if you will be gracious enough to tolerate me for a few moments; not be too critical and impatient; and keep in mind that this weak spot on this evening's program will be more than compensated by the address of Dr. Fishbein, I will try to prove to you that I am approaching the stage of convalescence, and may recover.

It seems to me that inasmuch as this meeting marks the 100th anniversary of the first real medical convention held in Ohio, it will be timely for us to think and talk for a brief time about our organization—The Ohio State Medical Association—and consider what it stands for; what it has accomplished; what it means to you and me; what it can do for us in ensuing years; what our attitude toward it should be; and how we can insure its growth and advancement.

I do not intend to discuss serious economic and social questions, having a direct bearing on the practice of medicine and involving perhaps the destiny of the medical profession of this country.

This should not be interpreted to mean that I believe these critical issues are not of major importance for all of us. Quite the contrary. They are matters of deep concern. We must have information about them. We must give them studious consideration. We must combine action and thought when and where they affect public health and the interests of the medical profession.

However, many of these questions have been adequately summarized in the annual reports of our State Association committees and others have been, or will be, discussed on this Annual Meeting program by those well qualified to do so.

OBJECTIVES OF ASSOCIATION'S FOUNDERS

What I have to say will deal for the most part with problems which are exclusively *our* problems; which we alone must solve before we are in a position to attack questions affecting society generally.

It seems to me that too many physicians are either unfamiliar with or have chosen to ignore the objectives and purposes of our organization. Too frequently we forget why we have a statewide organization; what it has meant to medicine in Ohio during the past nine decades.

I had the pleasure some time ago of reading an historical review of the early period of medical organization in Ohio, presented by the late Dr. Edward B. Stevens, Cincinnati, at the Twenty-Fifth Anniversary meeting of the Ohio State Medical Association in 1870.

In his introduction, Dr. Stevens made these observations, which I recommend for your earnest consideration, since they express what doubtless was in the minds of our pioneering colleagues when they assembled to form the Ohio State Medical Association:

"All excellence is the result of individual effort. But social progress, and the success of great enterprises, imply combination of labor. These two then go together—individual exertion and organized effort. The silent ant carries to its home its daily earnings—but after all it is a poor silent ant—though ever busy. The winter's store is the aggregate of successive accumulations of the colony.

"All important social results are typed in this general proposition.

"Much that we do as individuals is only selfish—but wiser and better councils and purposes, aggregate the selfish labors of the individual and develop the features of general advancement.

"Those who love the profession of medicine have steadily and steadfastly worked upon this idea. The profession of medicine in its purity—and the profession of medicine in its greatness—is the result of this sort of aggregation of personal effort, and combined or organized plan.

"Our fathers were, from the beginning, well aware of the power of associated effort to promote personal and professional culture, and advance personal and professional harmony."

A challenge to future generations of physicians is found in the closing words of the Cincinnati physician. To quote:

"This closes up this third epoch of our state organization—the first of our history as a compact, living, working association. The history is a worthy one. From days of pioneer life and its privations, we have come forward to a day rich in civilization and refinement. In all its development the society has done its honorable share and borne its part in the heat and burthen.

"Let us anticipate great things in the mighty stretch of the future that spreads out before us.



RALPH R. HENDERSHOTT, M.D.,

President of the Ohio State Medical Association for the Year, 1935-1936

Few of us who celebrate this day will probably be spared to enjoy the golden anniversary; one by one we shall have done our part—well or ill—and wrapped in our last garment—go Home. But one by one, as we cease our labor, I trust the heartfelt aspiration will still embrace the society in all its past, and hope for it the realization of the words of the great English lawyer, in regard to the British Constitution—'Esto Perpetua'. Not only may it be perpetual, but still better let us adopt the motto of old Maryland—'Crescite et Multiplicamini'."

In my opinion here is a sermon for all of us, especially appropriate at this time when we are confronted with a new epoch in social relations and are beginning to emerge, we hope, from a period of trials and tribulations comparable to the difficulties and privations which were endured by those who took part in the early activities of our Association.

It is important that we have a clear understanding of the motives of those farsighted gentlemen who founded the Ohio State Medical Association and take inventory to see if we, their successors, are doing everything possible to perpetuate and actuate its basic purposes.

THREE FUNDAMENTAL FACTORS

Let us analyze our State Association. It is a federation; a unit brought about by the act of uniting separate groups to form a sovereign power so that each of the united powers retains the management of its local affairs but so organized that through the combination of effort the interests of all will be promoted and enhanced.

Three factors are fundamental in the present organization of the medical profession of Ohio.

First, the individual physician.

Second, the county medical society or academy of medicine.

Third, the Ohio State Medical Association, representing concerted, organized effort on the part of individual physicians and local medical societies.

Each is dependent upon the others; weakness on the part of one is certain to be detrimental to the interests of all.

It is perfectly obvious that the serious problems confronting the medical profession cannot be solved and the high purposes of medical organization achieved by individual effort.

Yet, we should not forget that individual initiative, enterprise and interest are indispensable factors and basic elements in the type of aggregate activity necessary to advance the cause of scientific medicine and safeguard the material interests of the medical profession.

INDIVIDUAL INITIATIVE AND EFFORT

Imagine what a virile organization we would be if every member of this Association would personally undertake to promote the purposes to which our organization is committed, namely: To extend medical knowledge; elevate the standards of medical education; encourage the enactment and enforcement of just medical laws; promote friendly intercourse among physicians; safeguard and foster the material interests of all physicians; enlighten and direct public opinion relative to the social aspects of medical practice; and make the profession more capable and honorable within itself and more useful to the public. This may sound idealistic and unattainable. Yet, in my opinion, this ultimately may be accomplished.

Unfortunately, there are some physicians—members of their local medical society and the State Association—who fail to realize they have obligations to their colleagues and their profession, as well as to themselves.

Moreover, they seem to be unable to understand that the effectiveness of organized activity is measured in terms of interest and effort on the part of individuals participating in the benefits of such activity.

We realize that physicians are individualists. The character of their work makes them so.

For that reason, we cannot expect all physicians to think alike; act or react alike; or have the same interests or aspirations.

However, these differences are not, and should not be, obstacles to active participation by all of them in the functions of medical organization.

Variety is the spice of life; also of organization activities. The more viewpoints the merrier. Let us argue and debate over methods of procedure but, for goodness sake, let us show some animation and interest.

Personally, I feel we have little to fear from occasional disagreements in our ranks for I firmly believe that the great majority of physicians are in perfect accord with the fundamental principles and sound policies for which medical organization stands, and in the final analysis will be united on major issues.

INDIFFERENCE OUR BIGGEST WEAKNESS

Our biggest weakness and greatest danger lies in the fact that too many of our members have assumed an attitude of utter indifference; an attitude of laissez faire, if you please.

This is one of our most difficult problems. Unless we succeed in stimulating thinking on the part of our own members and in bringing about active participation by them in the affairs of medical organization, we cannot progress; we will be unable to become a potent factor in the solution of great social and economic problems directly affecting the practice of medicine; we will lose ground and the good which has been accomplished by concerted action in past years will vanish.

This is the challenge which confronts us.

I am confident we will meet it but the stimulus must come from those who have not permitted their interest to lag; those willing to concentrate

their efforts on the task of reviving enthusiasm and activity; and those who believe, as I do, that our State Association is the key to the advancement of medicine in this state and should have the allegiance, unswerving devotion, and active interest of everyone of its 5400 members.

COUNTY SOCIETY MOST IMPORTANT UNIT

It has been said that the county medical society is the most important unit of medical organization.

This is true, and to paraphrase the famous quotation of the late Theodore Roosevelt: "Every physician owes some of his time to the upbuilding of his county medical society".

Our Association has achieved much and has become a powerful influence for good and progress because Ohio has had many alert and aggressive county medical societies.

However, our records disclose that some of our county medical societies have failed to meet their obligations to their own members, the State Association, and the profession of the state generally.

This is not only regrettable but disquieting, especially at this time when it is essential that the medical profession make its influence felt in every corner of the state.

I cannot over-emphasize the importance of strengthening — reviving, if necessary — every county medical society of the state during the ensuing months.

Every eligible physician in every community should be enrolled in the medical society of his county.

MUST SELECT OFFICERS WITH CARE

Officers and committeemen of county societies should be selected with the utmost care.

Occasionally, men are elected to high offices in the county medical society simply because they have personal aspirations or because others, more capable perhaps, are unwilling to assume the responsibilities such positions entail.

The president of a county medical society, in my opinion, should rank high professionally; have the peculiar temperament which fits him for leadership; and have the respect of the people of his community. He should have enduring faith in the value and importance of medical organization and be willing to make sacrifices of time and energy to efficiently discharge the duties of his office.

I will admit it is not always easy to find the right man for this important office but usually he may be found if the membership of the society is sufficiently interested to make the effort and exercises sound judgment when the time for filling executive offices arrives.

SECRETARY HAS GREAT RESPONSIBILITIES

The office of county society secretary is one of the most important, if not *the most important*, position in medical organization. The success and influence of the average county medical society are in a sense comparable to the initiative and ability of the secretary. If he is alert, conscientious and not afraid of hard, exacting work, the society is almost certain to be an aggressive, dependable body; if he is not, the society is doomed to failure.

Those societies which have contributed much to the activities of our State Association are in every instance those which have been farsighted and wise enough to fill the offices of president and secretary year after year with well-qualified men.

The same may be said of other offices and committee assignments. For example, a county society can quickly become an inactive group unless the program committee is on the job. Meetings must be made attractive and educational. Members will quickly lose interest unless they are given something worth while and an opportunity from time to time to make personal contributions to the educational program of their society.

All of us are enthusiastic about the extension of post-graduate opportunities and facilities, realizing that the successful physician is he who keeps pace with advancements in the art and science of medicine.

Yet, too few of us realize that the great majority of practicing physicians depend almost entirely on presentations at county society meetings for information with respect to scientific progress and regard this as a foremost opportunity for the exchange of experiences on the handling of cases.

For that reason we should make each program a real contribution and something of distinct benefit to those who are expecting medical organization to furnish them with educational opportunities.

PUBLIC RELATIONS COMMITTEE ESSENTIAL

Then too, let us not forget the importance of a strong committee on public relations.

Today the county medical society must play a major role in community life. It must build up good will and guide public opinion on medical and public health questions. Proper contacts must be made with other groups and the society must take the lead in the medical and public health activities of the community.

The job of the committee on public relations is to see that these contacts are formed; to act as a liaison between the medical profession and the laity.

Obviously, the personnel of this committee must be chosen with great care. An attitude of indifference on the part of any member of the committee should not be tolerated.

Now is no time for the medical profession to sit on the sidelines and watch others take the leadership in activities which should be directed by the medical profession.

However, this is what is happening in some communities. It will continue to occur unless the local medical society awakens and through an alert public relations committee makes its influence felt and gives the public to understand that the medical profession is capable of assuming responsibilities and willing to do so.

What has been said also applies to the legislative committee of each component society.

INTEREST IN LEGISLATION NECESSARY

All of us know that medical organization has been compelled, especially in recent years, to increase its interest in governmental and legislative affairs. This has been distasteful to some. Nevertheless, we have had to be practical to safeguard our interests and those of our patients.

Personally, I believe medical organization as such should be non-political and non-partisan.

At the same time, I cannot subscribe to the opinion of some that as an organization we must scorn having anything to do with legislation and government.

Being vitally interested as an organization in questions involving public health administration, medical education, medical licensure, medical practice, etc., and as individuals in governmental administration generally, we cannot divorce ourselves from politics, using the term in its broadest sense, and legislative and governmental affairs.

As an organization we must base our stand on these questions on fundamental principles and policies to which we as members of medical organization have subscribed. As individuals we may for the most part follow the dictates of our own judgment and conscience, keeping always in mind, however, that frequently personal viewpoints must yield to what is for the best interests of our profession and the public.

This being the case, the reasons for an aggressive, competent legislative committee or committeeman in each county are apparent.

EFFORTS MUST BE COORDINATED

We must depend upon the legislative committeeman to take the lead in such activities. It is his duty to keep the membership informed on local and state developments; serve as a contact unit between the local society and those directing legislative activities for us in Columbus; and give us the word when to swing into action for or against proposals of direct interest. Votes for or against legislative proposals are made through local contacts and conferences. The legislative committeeman is the key man. Unless he is fitted for this assignment and is energetic, the results will be disappointing. Of course he cannot work single-handed. He must have your active support and assistance. Put the right man in this responsible position and back him up 100 per cent, and your results will be surprising.

We might go on indefinitely enumerating activities which can be undertaken by every county society and which can be made to function if the right men are selected to direct them and the membership rallies to their support.

You are familiar with opportunities awaiting your society—perhaps some of them have been overlooked or muffed. All that is needed to make the average county society a more valuable asset to the community and of greater benefit to its members is a little ingenuity, coordination of effort, and intelligent leadership.

Don't expect the officers and committeemen to do all the work. They can't. You must help. If your county society is not functioning effectively, take an inventory. The fault may be because you and a large number of your colleagues are not contributing anything. If the officers and committeemen are shirking their duties, gently but firmly call them to account or replace them. You are the "doctor" and the "patient" is in your hands.

TYPES OF MEMBERS SUMMARIZED

Being individuals of varying types and characteristics, all members should not be expected to give an equal amount of support to medical organization. However, some measure of active support, large or small, from every member should be anticipated; in fact, required.

Occasionally, some physician takes it upon himself to belittle the value and importance of medical organization; scoff at its activities; and unfairly criticize those who have sufficient interest to take the lead in its undertakings.

A check-up reveals that ultra-critical members usually belong to one of the following groups:

Those who are disgruntled because of personal hypersensitiveness or some imaginary grievance.

Those who have found medical organization an obstacle to their selfish purposes or questionable practices.

Those who are pathetically ignorant of the motives and functions of medical organization and who have contributed little, if anything, to it.

Those who by nature and disposition are never satisfied with anything unless it is done by them or conforms to their narrow viewpoint.

By this frank analysis of some of our members, I do not wish to imply that any member should be deprived of the right to criticize medical organization or those in executive and administrative positions. An organzation thrives on criticism if it is constructive and the intention of the critics are sincere. Criticism of this kind should be welcomed and solicited.

Doubtless we could survive as an organization if this small group of constantly dissatisfied members would withdraw from medical organization. However, I seriously doubt if this is the proper procedure.

MAKING USE OF OUR TALENT

There are few physicians who cannot be useful and valuable members and none who can afford to be without the benefits afforded by membership in medical organization.

I believe that many of those catalogued as "knockers" can be converted into useful members if proper methods are taken to eliminate misunderstandings, provide them with a better understanding of the value and functions of medical organization, and give them an opportunity to utilize their initiative and energy in constructive organization activities.

Obviously we should have little patience with those who habitually wink at professional ethics and engage in dishonorable practices. Medical organization does not need members of this type and is derelict in its obligations to the public if it refrains from initiating disciplinary actions against them.

In my opinion destructive criticism will be minimized if every member will ask himself these questions:

What am I contributing to the cause of organized medicine?

Do I attend the meetings of my county medical society and the State Association?

Have I ever read a paper or taken part in scientific discussions at these meetings?

How many constructive suggestions have I made to the officers and committeemen of my local society and the State Association?

Do I read the *Ohio State Medical Journal?*

Am I informed on the purposes and activities of medical organization?

How many times have I volunteered to assist in county society and State Association projects?

Do I cooperate when requested?

Have I ever made an effort to promote the objectives of medical organization among my lay friends and acquaintances? those in public offices? members of the Legislature?

Have I done my part or am I receiving benefits from medical organization gratis?

BASIC FACTORS IN STATE ASSOCIATION

While considering the third important factor in medical organization in Ohio—The Ohio State Medical Association—please keep in mind this fact: Our Association is not an independent, self-perpetuating, self-sustaining agency but a collective body, made up of more than 5,000 individuals and eighty odd separate groups who are expected to supply the energy which makes the wheels of the State Association revolve.

If that energy is not supplied, the activity of the State Association will cease.

The State Association is not unlike but very much like, the county medical society. To be successful it must have the active interest and support of every local medical society and every member of those societies. It must have able leadership and qualified committeemen. It should at all times offer services and benefits which its members cannot secure elsewhere. It must be aggressive, and if need be, militant.

It is unnecessary at this time to summarize the many services and benefits the Ohio State Medical Association provides for its members. These are well known to all who have kept in touch with its activities. I hope that its constructive enterprises can be doubled and tripled during ensuing months and years. This is possible if every member will do his part.

The Ohio State Medical Association from the beginning has had leadership of the highest type. With few exceptions its presidents and other officers have been men of vision, sound judgment and unusual initiative.

Over a long period the Council has with few exceptions been composed of men sincerely and enthusiastically interested in the purposes of organized medicine; unselfish, conscientious men who have made great sacrifices and labored industriously in the interests of the medical profession of Ohio. The same is true of those who have taken part as committeemen. Also, we have been fortunate in having had efficient and loyal employes in our State Headquarters Office.

Yet, their efforts would have been futile had they not had the active support of the component county medical societies and the cooperation of a vast majority of the members—the field workers, so to speak.

COMBINED ACTIVITY INDISPENSABLE

We who are about to carry on where others have left off will be confronted with an identical problem. We will fail unless we have the assistance of you and your colleagues. We cannot perform miracles. Remember we are human beings—just ordinary physicians, deeply interested in keeping the medical profession at the top and willing to sacrifice to make this possible, but at the same time endowed with human frailities.

During ensuing months, the officers and members of the Council will be called upon to consider questions of great importance to you and the profession generally. As in the past, we will base our decisions on the policies laid down by the House of Delegates, consisting of your chosen representatives. We will act in accordance with what we honestly believe to be the viewpoint of the majority of the membership and endeavor to keep our decisions in line with what we believe will be for the best interests of the profession and the public.

Incidentally, permit me to call your attention to the fact that some of our county societies are rarely represented at the annual sessions of the House of Delegates; others by delegates who

show, little if any inclination to take part in the proceedings. We must be guided by your viewpoints, voiced by your delegates. It is up to you to remedy this situation by electing alert, well-qualified delegates and insisting that they attend all sessions of the House of Delegates.

THE COUNCILOR AND HIS RESPONSIBILITIES

The office of Councilor is in my estimation the most important and at the same time most difficult official position in our State Association. Having had the honor and privilege to serve on the Council, I speak advisedly.

Sometimes I wonder if the membership is fully aware of this fact.

The Council is your governing body. A Councilor is the official liaison between the members and county societies of his district and the State Association. He is a trouble-shooter de luxe. He is expected to assist with your local problems, take an active part whenever possible in your local activities, and serve as your agent in administration of the affairs of the State Association. He is expected to visit the societies of his district frequently; furnish you with accurate and official information of various questions; and secure your suggestions and advice to guide the Council as a whole in its deliberations.

On the other hand, your Councilors will expect certain assistance from the members and societies of his district. He needs, and is entitled to, your active support and cooperation. Unless you keep him posted on local problems and local developments, he will be unable to assist you and will be unable to transmit to the Council and officers information of value and importance.

Each Councilor and the societies of his district should work in unison; with perfect coordination. The State Association cannot function effectively and smoothly unless this is the case.

THE FUTURE AND ITS POSSIBILITIES

If you fail him the efforts of your Councilor will be futile; the State Association will suffer. If your Councilor neglects his official duties and dodges his responsibilities it is your prerogative to call him to account; replace him if he continues to do so.

Remember that the Council will be ready and anxious to assist any member and any county society during the coming months.

Also remember that it will be unable to find the proper solution for all your difficulties. There are local problems which you and your local society alone will be able to solve; at least make an effort to do so.

Yet, if the proper cooperation and coordination is developed between the various county societies and the members of the Council, it will not be difficult to develop practical procedures for tackling both local and state-wide questions.

Development of greater teamwork between the Council and the membership is certain to reflect in the activities of the committees of the State Association and the work of our Headquarters Office.

In conclusion, permit me to solicit your united, active assistance during the next year. I am fully aware of the great responsibilities which will be mine. I will need your help and counsel.

Let us take as our slogan, the frequently-quoted statement of Former Vice President Charles E. Dawes, to wit:

"If you work in a profession, in Heaven's name work for it. If you live by a profession live for it. Help advance your co-worker. Respect the great power that protects you, that surrounds you with the advantages of organization, and that makes it possible for you to achieve results. Speak well for it. Stand for it. Stand for its professional supremacy. If you must obstruct or decry those who strive to help, why—quit the profession. But as long as you are a part of a profession, do not belittle it. If you do you are loosening the tendrils that hold you to it, and with the first high wind that comes along you will be uprooted and blown away and probably you will never know why."

—OSMJ—

Sixth District Meeting, Nov. 19, at the Youngstown Club

The Sixth District Meeting will be held Tuesday, November 19, at the Youngstown Club, with members of the Mahoning County Medical Society acting as hosts.

Beginning at 2:00 P.M., a program will be presented by Youngstown physicians. Dinner will be served at 6:30 P.M.

The evening session will begin at 8:30. Dr. H. L. Backus, Professor of Medicine, University of Pennsylvania, will be the speaker.

—OSMJ—

Lima Post-Graduate Well Attended

Approximately 150 physicians attended the Sixth Annual Post-Graduate Week of the Lima and Allen County Academy of Medicine, held at Lima, September 23-28.

Dr. Robert F. Ridpath, Temple University, Philadelphia, and Dr. Edward B. Davis, Chicago, gave the lectures.

Members of the committee in charge of the meeting were: Dr. E. C. Yingling, chairman, Dr. Virgil Hay, Dr. Edward B. Pedlow, Dr. H. L. Stelzer and Dr. J. R. Tillotson.

—OSMJ—

Nurses to Meet, Nov. 11-13

A joint institute of the sections on Nursing Education, Public Health and Private Duty Nursing of the Ohio State Nurses' Association will be held at the Deshler-Wallick Hotel, Columbus, November 11, 12 and 13.

THE TREATMENT OF DIABETES IN CHILDREN

By MORRIS DEITCHMAN, M.D., YOUNGSTOWN, OHIO

IN the pre-insulin era the annual death toll of diabetic children was about 1,400. The survival of these children, since the discovery of insulin, is making their care a major medical problem. Before the insulin era so few children lived over six months from the time of onset, that it became customary to predict a fatal outcome for all.

Joslin,[1] reviewing 750 diabetic children seen by him from 1898 to 1931, shows what a revolutionary change has occurred, and emphasizes the increasing problem the care of these children has become.

Period	Number of cases	Number living	Per cent living
Naunyn—1898-1914	61	1	2%
Allen—1914-1922	170	40	28%
Banting—1922-1931	519	483	98%

After E. P. Joslin

Prior to the Banting era the diabetic mother was very unlikely to give birth to a living child, for pregnancy terminated in still-birth or spontaneous abortion. The control of this factor has resulted in a further increase in the juvenile diabetic population, for diabetes is inherited as a Mendelian recessive. Joslin[2] estimates the annual increase of diabetic children at 1,000, and believes that by 1944 there will be a total juvenile diabetic population of about 15,000.

The survival of the diabetic child has, in a large measure, been due to control of diabetic coma, since 61 to 66 per cent of all deaths in juvenile diabetics were due to this cause. If this cause of death could be entirely eliminated, the death rate of these children would be reduced from 1:100 to 1:300.

Henry John,[3] in his review of 214 children, shows the high mortality in the first year of diabetes. It is during this period of accommodation, before the patient and family have familiarized themselves with the routine, that coma most often occurs.

Total	Total Living	Died	Died of Coma	Died in 1st yr.	Diabetes over 10 years
214	186	28	18	11	48

After Henry J. John

Much interest has been aroused, in the last few years, in the heredity of diabetes. In spite of the high foetal mortality, it was still obvious that there was a higher incidence of diabetic children in diabetic families than in the normal population. Gregory Pincus[4] and Priscilla White investigated 675 diabetic families. From their study they concluded that diabetes is inherited as a Mendelian recessive, and, if that is so, the incidence of diabetes is predictable on the following basis:

1—If two diabetics marry, all of the children will be diabetic.

2—If a diabetic marries a non-diabetic, with a diabetic heredity, 50 per cent of the children will be diabetic.

3—If two non-diabetics, both having a diabetic heredity, marry, 25 per cent of the children will be diabetic.

4—If a diabetic marries a non-diabetic, with a clear heredity, none of the children will be diabetic.

The treatment of the uncomplicated diabetic is based on diet, insulin, and exercise, bearing in mind the following four control standards that must be fulfilled:[5]

1—Adequate nourishment.

2—Blood sugar below 200 mgms.

3—Glycosuria less than 10 gms. in 24 hours.

4—Cholesterol content of the blood below 230 mgms.

Failure to maintain these control standards will convert an uncomplicated case into one that will show evidence of transitory or permanent deficiency.

DIET

There is a definite trend toward standardization of the diabetic diet on a rational basis. Bizarre diets have been discarded in favor of the Sansum[6] or Geyelin[7] high carbohydrate diets. Instead of the restricted, inadequate diet of a decade ago, the following basic diet, with some variation, is generally recommended.[8]

Age	Cal. per kg.	Total Cal.	P. Per kg.	Diet in gms.
5	75	1400	3.	C-140- P-60- F-70
10	65	1600	2.	C-160- P-70- F-80
15	45	1900	1.5	C-180- P-85- F-90

From Priscilla White

Caloric requirement cannot be arbitrarily fixed by the age of the patient, as each child will have to be individualized on the basis of relative metabolic efficiency, activity, height and weight.

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Caloric intake must be increased 5 to 10 per cent every six months to produce a normal increase in height of about two inches, and in weight of about six pounds. Such foods as will provide adequate vitamins and minerals must also be included in the diet to avoid the deficiency diseases.

It is quite evident that the under-nutrition and high fat diets are both passing.[9] The severe restriction of the Allen era, which is now unnecessary, unquestionably saved the lives of many diabetics. Without this restriction it would have been impossible for them to survive into the present era of normal diet, with its attendant normal metabolism. The high fat diet with its incidental obesity, ketosis and hyperchlorestremia was contrary to normal diet requirements and violated at least one of the control standards.

In addition to fulfilling all of the control standards, the high carbohydrate diet has these other advantages:[7]

1—From the standpoint of body metabolism, carbohydrate is the most economical and readily available source of energy.

2—The hypercholestremia of those patients who were on high fat diets disappears as the normal ratio of 4 C; 1 F is approximated.

3—There is increased insulin efficiency on the Sansum type of diet. Carbohydrate can be substituted for fat without an insulin increase. This is not due to caloric reduction, as on the same caloric intake, with almost twice as much carbohydrate, the patient will fulfill the control standards without increased insulin. Subsequently, as tolerance is increased, insulin can be reduced in practically all patients.

4—The high carbohydrate diet is much less costly.

INSULIN

A normal diet cannot be given without insulin. The total dosage of insulin is variable and is usually best divided into three parts. Of the total dosage, 5/11 are given one-half hour before breakfast, and 3/11 one-half hour before dinner and supper.[6] If there is a tendency to spill sugar in the morning it may be necessary to give two to four units about 10 P. M. If less than 20 units of insulin will maintain a sugar free urine, only two doses are given, 5/8 of the total dosage before breakfast, and 3/8 before supper. Frequent small doses of insulin are more effective and much less likely to produce insulin reactions, and are therefore preferred.

EXERCISE

The diabetic child should never be restricted as to exercise but should play and work with his normal brothers and sisters. Exercise increases insulin efficiency. Increasing the activity of the diabetic child will, without any other change in routine, markedly reduce glycosuria.

INDIRECT COMPLICATIONS

The most common indirect complications are pseudodwarfism, premature arteriosclerosis and juvenile cataract.[8] Of these, pseudodwarfism results either from failure to increase the diet and insulin, or from diet breaking. Once pseudodwarfism has been established, very little improvement can be expected from correction of the dietary deficiency, as permanent changes already have taken place. *X*-ray studies of the long bones of these patients show definite evidence of growth arrest.[12] An attempt to stimulate growth with pituitary and thyroid extract resulted in some additional improvement in one of our children, but this improvement has been comparatively slight.

Premature arteriosclerosis and juvenile cataract are believed to be due to hypercholestremia existing over a long period of time. Adequate carbohydrate and restricted fat diets should eliminate these complications.

DIRECT COMPLICATIONS

Hypoglycemia and coma are the common direct complications. Hypoglycemia is sudden in onset. It must be differentiated from diabetic coma, and until the differential diagnosis has been established, insulin should never be given an unconscious diabetic child.

The first symptom is usually gnawing epigastric pain, which is followed by listlessness, excitability or unruliness. Any character or personality change in a diabetic child may be a manifestation of hypoglycemia. Glucose by any route will produce a quick response, although, in severe hypoglycemic reactions, glucose intravenously may be necessary. The necessity for this can be obviated if early recognition of a mild hypoglycemic reaction, before actual unconsciousness has set in, is immediately followed by oral administration of a little orange juice, a cube of sugar, or food.

COMA

The chemistry of diabetic coma is that of progressive severe acidosis, terminating in unconsciousness. Insulin deficiency results in failure to convert carbohydrate to glycogen and this permits the formation of acetone bodies from the incomplete metabolism of fat and protein. Almost at once, water metabolism is upset and dehydration occurs. Rolli[11] and Waterhouse believe that coma does not supervene until diuresis and vomiting have caused such severe anhydremia that there is concentration of all metabolites in the blood. Finally, the incomplete combustion products of fat accumulate in the liver and muscles replacing glycogen. Fatty degeneration of the liver develops and further impairs the metabolism of glycogen. Unless this cycle is interrupted, death usually occurs.

TREATMENT OF COMA

Coma can be prevented if there is early recognition of beginning acidosis accompanying coryza, tonsillitis or one of the acute exanthemata. Insulin must, at once, be increased, since it not only becomes less efficient but is also partially inactivated by infection. Additional glucose, in a readily available form, must also be provided, and, as orange juice is palatable as well as readily assimilable, 200 cc. can be given three or four times a day, covering this with eight or ten units of insulin. Many workers believe that supplemental glucose is more quickly utilized than the excess in the circulating blood. Even with insulin enough to convert this excess into glycogen, the amount thus made available is insufficient to protect the glycogen reserve.

The treatment of fully developed coma varies somewhat, especially as to the use of glucose routinely. Joslin does not advise its use until the urine is almost sugar free. He advocates frequent doses of insulin. On the other hand, Murphy and Moxon[10] give glucose with each dose of insulin, and usually initiate treatment with 1,000 cc. of 10 per cent glucose subcutaneously, covered with 50 units of insulin or one unit for each 2 grams. They believe that they thus provide available glycogen to counteract acidosis, and restore the depleted liver and muscle glycogen. In our experience, we find that a stomach tube, inserted either orally or intra-nasally and left in for 24 hours, is of great assistance in treatment. By means of the tube we give alternately 200 cc. of water and 200 cc. of 10 per cent glucose or orange juice every hour. Thus, in 24 hours the patient received about 5 liters of fluids containing about 240 grams of glucose. The glucose is made available by one unit of insulin for each 2 gms. of glucose. The insulin dosage is decreased as the urine becomes free of acetone and diacetic acid, and the disappearance of these products signifies that acidosis is controlled. Hypoglycemic reactions are avoided by extreme conservatism in insulin dosage, for many children in coma are thrown into severe insulin reactions which terminate fatally. Glycosuria is disregarded until a full diet can be ordered, and then the maintenance requirement of insulin is established.

In an extremely severe acidosis, treatment is initiated with 10 or 15 units of insulin followed by an intravenous infusion of 10 per cent glucose and insulin. Glycogen is thus provided quickly, until the orally administered glucose is available. External heat, enemas for distention, and stimulants are given as necessary.

SURGERY AND THE DIABETIC CHILD

Any surgical procedure involving a general anaesthetic is a dangerous adventure for the diabetic child. It has been shown that anesthesia destroys much of the glycogen reserve of the liver, and with the added post-anesthetic nausea and vomiting there is the inevitable danger of acidosis. In addition to this there is a tremendous loss of body fluids by hyper-ventilation, excessive perspiration, and occasionally hemorrhage. Whenever possible, therefore, the diabetic child should be prepared for surgery with large amounts of fluids, and 50 to 100 grams of glucose daily in addition to the regular diet. This extra glucose, which is to provide a reserve store of glycogen, is covered by an adequate amount of insulin.

After operation, subcutaneous infusion of saline and glucose, in amounts approximating the normal glucose intake of the patient, are administered. Insulin in small doses is given after each infusion of glucose. After the first 24 hours the glucose requirement of the patient can be supplied in the form of lemonade, orangeade, or other fruit juices. A full diet is not given until the urine specimens are free of acetone and diacetic acid.

In closing we must remember that the last word in the care of the diabetic child has not yet been said. We must anticipate further changes comparable to the changes that already have been made. An open mind is essential if the child diabetic is to receive the benefit of further progress.

SUMMARY

1—Diabetic children are to be with us in increasing numbers.

2—High carbohydrate diets are the greatest advance in diabetic care since insulin.

3—The life expectancy of the child diabetic is excellent if coma can be avoided.

CENTRAL TOWER.

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—OSMJ—

Cincinnati—Professor Henri Coutard, chief of service of roentgenology, Curie Institute, University of Paris, recently lectured at Wilson Memorial Auditorium, University of Cincinnati, on "Radiation Therapy", under the auspices of the University and the Cincinnati Cancer Control Clinic.

SOME EFFECTS OF THE UPRIGHT POSITION OF HUMANS UPON PREGNANCY, PARTURITION AND THE PUERPERIUM

By ANDREWS ROGERS, M.D., Columbus, Ohio

EVER snce the anatomical studies of Vesalius, Eustachius and Fallopia first placed medicine upon a scientific foundation, the effect upon parturition of the closed pelvic girdle has been recognized. In the seventeenth century Heinrich Van Deventer's (1651-1724)[1] monumental work on the human pelvis was in effect largely intended to furnish a scientific base on which to stand in the efforts to design measures necessary to overcome the disproportion between passage and passenger that inevitably occurs in the rigid pelvic girdle of human beings required by their upright position and that does not occur in the non-rigid one of four-footed creatures.

It was natural and logical that the injuries incidental to childbirth should have received the first thought and attention of the medical profession, that the idea that every parturient woman was of necessity a wounded woman should have originated and that its early efforts should have been directed almost exclusively to the prevention and repair of such injuries. With the advance of scientific medicine, the development of laboratory methods, of clinical diagnosis and techniques for the study of the operation of all the internal structures (internal medicine), it has been inevitable that a change has occurred in the direction of thought and that now a great deal of time is devoted to the recognition and study of the effects of pregnancy upon the internal organs, as well as of parturition upon the parturient canal. Bumm[2] was among the earliest to recognize this, at least to put it into print, when he called attention to the fact that the strain of pregnancy carried many of the important structures of the maternal organism almost to the breaking point and although, as he said, healthy, vigorous women could go through this ordeal without actually breaking, still, damage, especially on repeated experience, was in a high degree likely. Therefore pregnancy and parturition should be considered more nearly pathological than physiological processes because the boundary between physiological and pathological in organs operating under a strain is really impossible to determine.

Hrdlička[3] has more recently observed that the great preponderance of skeletons of young females in aboriginal burying grounds could mean only that among primitive peoples childbirth carried a very heavy inherent mortality—too great for a purely natural physiological function.

The inhibition of the downward descent of the diaphragm by the encroachment of the fundus from below, near or at term, presents interesting possibilities. For the pregnant woman at term, practically no diaphragmatic breathing is possible and vital capacity is greatly curtailed, while in the four-footed position, the growing uterus falls forward and the fundus caudad toward the hind legs, thus creating a great pauch into which the intestines slide and so frees the diaphragm and in effect greatly promotes an increased vital capacity of the lungs at this time when more oxygen is so urgently required. The effect in the first instance on all bodily processes requiring oxygen for their completion will readily be appreciated. Incidentally, protein elements require the largest amount of oxygen for their complete oxidation, and their incomplete oxidation results in toxins of the urea type. In addition, the rise of the fundus high in the abdominal cavity, and the outward displacement of the lower ribs, results in a displacement of the heart, as was mentioned by Sir James McKenzie[4] in 1921 in his work on Heart Disease and Pregnancy. It was he who first pointed out that the idea of a cardiac hypertrophy of pregnancy that had prevailed for so long a time was not an hypertrophy at all, but that the increase in the area of cardiac dulness was actually due to a displacement of the apex outward, as a result of the rise of the fundus from below. Here, then, we have the inauguration of a vicious circle, because as McKenzie has demonstrated, the heart in this position operates at a great disadvantage; it finds that it is only with increasing difficulty that the various capillary circulations, among which are the kidneys, liver and brain, can be maintained and that there is inevitably in all of these a tendency for venostasis and congestion and the untoward conditions that will follow in such circumstances. So during the last weeks of pregnancy, at the very time when the greatest need for unimpeded activity of the maternal organism exists, we find that there is always more or less curtailment of essential bodily activities growing directly out of the upright position and that inevitably a certain per cent of pregnant women will be unable to complete these essential functions.

McKenzie's work was so carefully done, dealing as he did, first with the changes produced

Professor of Obstetrics, College of Medicine, Ohio State University, Columbus, Ohio.

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by pregnancy upon healthy women without previous cardiac involvement, that little can be added to this particular division of his work; to quote briefly:

"I found that in healthy women practically no changes in the circulation could be detected in the early months of pregnancy.

"Towards the sixth month the response to effort began to be restricted, i. e., breathlessness appeared after an amount of exertion which had hitherto been accomplished in comfort. As a rule this never became extreme, and the woman was able to attend to her household duties; she felt the breathlessness chiefly on going upstairs.

"About the seventh month the uterine tumour altered the shape of the chest—widening it out so that the circumference gradually increased. The chest was measured immediately under the breasts and, as full time approached, the circumference increased considerably, four to six or seven inches. Immediately after delivery the circumference diminished, and day by day it decreased till some weeks after confinement it had returned to normal.

"The following are examples:

CASE 1

	Inches
At full time	28
Immediately after birth of child	25½
Four days after birth of child	24½

CASE 2

At full time	29
Immediately after birth of child	26½
One day after birth of child	25½
Three weeks after birth of child	23½

"Coincident with the change in the chest circumference the heart was frequently displaced until the apex beat was pushed out one inch beyond the left nipple line, and upwards to the fourth interspace. After labour the heart gradually swung back into its normal position.

"It is well to bear this normal displacement in mind. For a long time it has been held that the left ventricle hypertrophies during pregnancy and undergoes some sort of involution after confinement. The evidence for this view has been based chiefly on theoretic grounds and on some very imperfect post-mortem observations.

"Accompanying this widening of the chest, there is a tendency for stasis to occur at the bases of the lungs. This will be dealt with in speaking of the failure of the right heart. In order to estimate the factors which embarrass the right heart, the lessened effect of the movements of respiration had to be considered. I found that normally there was a tendency to stasis *even in healthy women when pregnant.** In a number of patients the veins of the legs became swollen and varicose—in some there was considerable swelling and varicosity of the veins of the thigh, and of the vulva. Hemorrhoids were frequent. I lean to the view that they are the result of actual pressure of the pregnant uterus on the veins in the pelvic and abdominal cavities. My notes of cases of pregnancy show that even in healthy women, at this time, swelling of the legs was far from infrequent. It was usually slight, but sometimes became very considerable. As it tended to get worse toward the end of the pregnancy, and as there were no accompanying changes in the heart, I attributed it to the pressure of the uterus on the abdominal veins."

In the light of this latter statement of McKenzie's the urinary tract furnishes another vulnerable point. It has long been known that of all the organs in the body, the kidneys and ureters probably furnish the highest per cent of variations from the normal. No surgeon ever removes one kidney without being sure that there is another one. Pyelography has revolutionized the study of these organs. Because of the well known frequency of their variation from the normal, the Urological Department of the Medical College of the Ohio State University, in cooperation with the Department of Obstetrics, undertook a study of these structures. Approximately seventy-five cases were studied by pyelography and the observations were enlightening. Definite anatomical anomaly represented by upper urinary tract dilation was present in more than 80 per cent of all cases.* In all the cases of threatened eclampsia and eclampsia in this series, sufficient anatomical pathology was found to cause kidney insufficiency. It is readily seen therefore, that the increased abdominal pressure due to the rise of the fundus at term in the pregnant woman would mean that practically all the variations from the normal increased the opportunities for pressure to obstruct, and here then, with the diminished oxygen intake and consequent anoxemia, the faulty cardiac action and its evil effects upon the kidneys, liver and brain, and the active mechanical obstruction and consequent pressure stasis and dilatation in the upper urinary tract, we have a logical explanation as to why pre-eclamptic toxemia and eclampsia are peculiarly conditions of the last weeks of pregnancy and also peculiar to the human race. Conditions somewhat similar to these late toxemias that are occasionally found in four-footed animals, by the very rarity of their occurrence would only go to substantiate the contention that their relative frequency in the human race depends largely upon the added afflictions due to the upright position. That this is a true observation is established by the fact that late toxemia lends itself so readily and thoroughly to prophylaxis.

* The italics are mine.

*Results of this study are contained in a separate report by Dr. Taylor, Department of Urology, Ohio State University College of Medicine, to be published shortly.

Eclampsia is said by several authorities to be largely, if not entirely, preventable and the picture revealed by any set of statistics dealing with, first, cases that have received no prenatal care, second, those that have received partial prenatal care and, third, those that have received adequate prenatal care, is beyond controversy; yet all that is really done that is so effective is to relieve in various ways the strain upon certain capillary circulations, liver, kidneys and brain, compelled to work under a mechanical congestion and stasis. If there is any truth in the old adage, and there usually is some truth in the old adages not founded upon superstitution, that the proof of the pudding is in the eating, I might say that in the last one hundred cases (approximately) of eclampsia in which treatment based upon this conception of this condition, that is, a wet brain and edematous kidneys and liver, has been carried out, we* have lost only three—One died on the admitting car, one twenty minutes after admission and the third one hour and forty minutes after admission. We have not Caesareanized a case since this treatment has been instituted. Most have delivered spontaneously or with low forceps. A few we have bagged, and in a few cases we have done version and extraction.

It is impossible to pass from this subject without recalling to mind that the knee-chest position and the monkey-walk have recently been added to our regular ante-partum care as a prophylaxis and a treatment for upper urinary tract involvement either dilation or infection or both, and that pyelitis has long been recognized as a complication of pregnancy and the puerperium that occurs here much more frequently than in the non-pregnant state.

Quite recently Elftman[5] has reported some interesting work in the anatomical field dealing with the modifications in the human pelvis incident to the upright position and the loss of the caudal appendage. He states that man is the only animal that spends most of its active life in the upright position—the anthropoid apes do so only partially. They walk on their feet *and* hands, the monkey-walk, and sit in a way that supports the pelvic diaphragm.

Attention is called to the increased anterior curve and fixation in this position of the sacrum, and also of the anterior encroachment and slight mobility of the coccyx, but of even greater importance it is pointed out that the great and powerful muscles that motivated the tail have atrophied, disappeared or become rudimentary—and that the perineum has of necessity lost its slackness and become firm and rigid to a degree. From this it is evident that when the powerful tail was present, a backward swing opened the lower birth canal; the bony structure, lower sacrum and coccyx, and muscle structure, the then large and powerful coccygeus and pyriformis, levatores ani, etc., and the uterus pushed the head to the vulva. Then by a forward sweep of the tail, the head was brought into extention with one movement and was born. How different in humans, with the long battering of the head against the now rigid perineum, with the sub-occipital region of the fetal skull against the sharp edge of the under surface of the pubic arch. From one to two or three hours or even longer are now required to overcome the rigidity of the perineum, that was once accomplished by one sweep backward of the tail. Incidentally, the deformed, corkscrew-tailed Boston Terrier very frequently dies in labor if not Caesareanized, because it cannot complete the act of parturition. This pathology is the indication for the relief offered by low forceps and episiotomy, now so generally used to save time, to spare the outlet almost inevitable injury and to relieve strain upon the mother's heart and congested capillary circulation and nervous system. Further, an investigation by autopsy* into the death of babies dying in the first week post-partum, gave an overwhelming predominance to cerebral hemorrhage as the cause, and of these, over ninety per cent were babies born in spontaneous deliveries, and in eighty odd per cent of these cases, the hemorrhage was at the base of the brain directly under the point that had impinged under the pubic arch and so bore the strain of the perineal distention. Of course, here come forward the questions of hematopoietic and hematogenic qualities and characteristics. On such questions, we have little more than scratched the surface. Nevertheless, the mechanico-anatomical situation is clear, and again, we see that parturition in man is rather more a pathological than a physiological process. Finally, the almost universal use for some time past of the knee-chest position and monkey-walk post-partum to secure better involution and a normal ante-flexed position of the uterus is well established and tends further to confirm the contention that untoward conditions develop in humans due to the upright position.

It is of relatively little importance that this country stands at the foot of the list in world statistics on maternal deaths in childbirth—the differences between the figures in the official list is so slight as to be negligible, and may easily be more than accounted for by the greater frequency in this country of criminal or self-induced abortions with their very high mortality; the tremendous preponderance of our open country settlement as opposed to the almost entirely urban type of settlement in European countries, especially the Scandinavian countries, where the maternity death rate is lowest; and by the fact that ours is a mixed race instead of a pure strain. In this

*The Department of Obstetrics at Ohio State University, Columbus, Ohio.

*Conducted by Dr. H. L. Reinhart of the Department of Pathology, College of Medicine, Ohio State University.

connection Williams[6] and others have pointed out that a Caucasian head does not readily pass through an African or Indian pelvis. But it is a matter of the utmost importance that 15,000 or more women die in this country every year as a result of childbirth and that several times that number are damaged by pregnancy and parturition, and that because of their impaired health, their usefulness is greatly reduced and their happiness interfered with. With a more enlightened view toward this question of death incident to childbirth coming throughout the world we begin to see the probability of the lifting of the burden of abortion with its terrific mortality, from the shoulders of childbirth proper. With this gone, it leaves as the next great division the deaths due to the toxemias, particularly eclampsia, since toxic vomiting is rare, is in fact an acidosis due to dehydration and can easily be corrected and controlled. This division, the toxemias of pregnancy, still accounts for about 25 or 30 per cent of the fatalities. With a rational understanding of the etiology of eclampsia, we are able to see why our prophylaxis is so effective and to develop a treatment for the inevitable case that does not require hospitalization, and that is practically 100 per cent effective, a great deal can be done to reduce this remaining mortality. Next in order in fatality are infection (puerperal) and hemorrhage (post-partum) atonic, traumatic or both and it cannot be denied that these are not directly influenced by the increased length and severity of labor and parturition brought about by the modifications necessitated by the upright position in the human race.

I do not think that these ideas conflict in any way with the more plausible theories of endocrine disbalance as an etiological factor, in late toxemia; indeed, quite the contrary. However, cows, mares, and ewes have hypophyses, ovaries, suprarenals, thyroids, and so forth, but they do not have eclampsia.

To recognize then, that by reason of such modifications pregnancy and parturition in humans of necessity partake more of the pathological than of the physiological and to adapt our procedures to this view would appear to offer the only way to reduce a mortality rate that for some time, has seemed to have reached an irreducible minimum.

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NEW TREATMENT FOR CHRONIC ULCERS OF THE LEG AND FOOT

By C. H. VEROVITZ, M.D., CLEVELAND, OHIO

IT HAS been said, by both physicians and laymen, once an ulcer, always an ulcer. This expression is no longer necessary. I have seen several patients with ulcers of ten to 25 years' duration which have been healed. With the proper after care, they will remain healed.

The most common ulcers of the legs are due to varicose veins and syphilis. Other ulcers, which are less common, are due to diabetes, tuberculosis, traumatic, mycotic, arteriosclerosis, Burgers, Raynauds, cancer, drugs, and ulcers caused by *X*-ray burns.

Varicose Veins give rise to four types of chronic ulcers of the legs:

Type 1. Ulcers develop in areas surrounded by either small or large superficial veins. These veins are distal, proximal, medial or lateral to the ulcer, "so called feeders to the ulcer". (Fig. 1.)

The ulcer tends to "ride" upon a varicose vein, and even when induration is so extensive as to disguise the presence of a large vein behind the ulcer, the fluctuant tract leading into the ulcerated area can often be palpated. The presence of stagnating blood stretches, atrophies, and finally ruptures the skin. This is the most frequent type of varicose ulcer. In this type of ulcer, injection treatment with sclerosing agents is best. I have been using sodium morruhate, and recently, I am using a combination of sodium morruhate 5 per cent and 2 per cent quinine known as Moruquin, with success.

Type 2. Frequently, following an injury, an infection is present, and this infection, spreading to the adjacent veins, causes a thrombophlebitis, later small erosion of the skin and finally an ulcer. Sclerosing agents are used successfully after the phlebitis has subsided.

Type 3. The skin has been damaged by a previous thrombophlebitis, of several months'

In charge of the Varicosity Clinic, St. Vincent Charity Hospital.

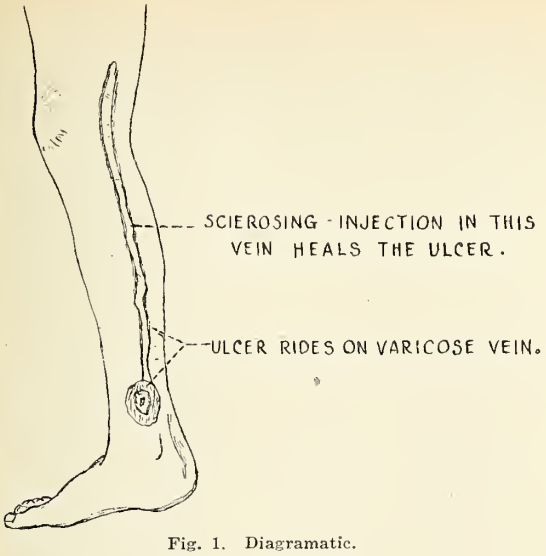


Fig. 1. Diagramatic.

duration. There are no visible or palpable veins in the area of the ulcer. This is called post phlebitis ulcer. (Fig. 2.) For this type, injection of autogenous blood is very good.

Type 4. This is the severe type of ulcer where the deep veins are involved, alone or combined, with incompetency of the intercommunicating veins or perforating veins. The valves of these perforators are absent or have become disabled. The burden of the already overloaded superficial system is actually increased. These perforating veins play more of a part in the localization of the ulcer than is generally believed. In the midcalf perforating veins are normally most numerous. The aggregate capacity of varicose veins is usually greatest in the middle half of the lower leg. It follows thus that stagnation is most marked here. If competent perforators are connected with such a lake, passive congestion will certainly be many times increased. It is, in fact, not at all unusual to find hugely dilated communicating veins, connected with the superficial varicose vessels, upon which an ulcer rides. In this type, both sclerosing solutions in the veins, and autogenous blood in the ulcer are given with success.

Pathology of the skin of a Varicose Ulcer resulting from a previous Phlebitis:

The skin surrounding the ulcer is hard and thick. Sometimes due to thickening of both skin and subcutaneous tissue, the skin cannot be raised from the base, due to loss of its elasticity. Varicose ulcers are surrounded by a diffuse brownish or bluish pigmentation. One finds this change extending either over a part, or the whole circumference of the limb, depending upon the extent of previous thrombophlebitis.

Bacterial Flora of an Ulcer of the Leg:

There is a mixture of organisms. We found staphylococci, pyogenes aureus and albus, gram positive hemolytic staphylococci, streptococci, micrococcus, tetragenous, and gram negative bacilli in the surface of the ulcer, and gram positive anaerobic bacilli in the slough. Occasionally these organisms invade the deeper tissues and lead to lymphangitis, cellulitis and sepsis. The low virulence of the organisms is caused by the lack of nutrition of the part. Various antiseptics are used which makes it an unfavorable habitat for bacteria, preventing marked infection. This lack of nutrition also prevents the ulcer from healing.

Histological findings of an Ulcer of the Leg:

The horny layers of the epidermis are deficient, thus causing the nucleated cells to reach the surface of the epidermis. The germinative layer is irregular and increased to several rows. The rete sends down prolongations to rete pegs in the derma. The rete pegs are hypertrophied in some places, in others on a few layers of epidermis are present and the corium reaches almost to the surface. The intercellular spaces of the epidermal cells are enlarged. The cutis shows thick fibers and infiltration with round cells, and blood pigment as a result of old bleeding. The elastic fibers

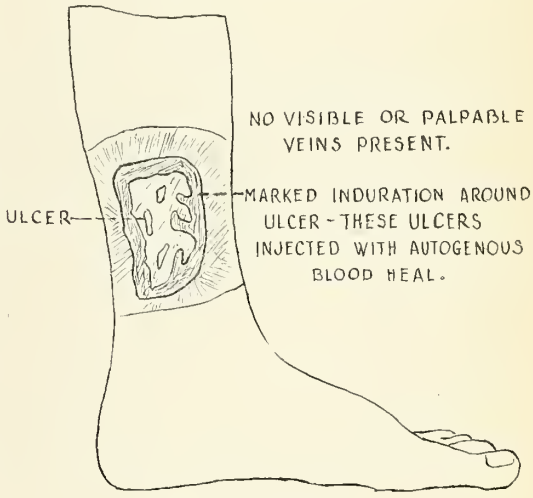


Fig. 2. Diagramatic.

have disappeared or are greatly diminished. Grave changes have taken place in the blood vessels. The back pressure from the large veins is carried through to the subpapillary branches, and capillaries. The minute veins are dilated, thrombosed and degenerated. The walls of the capillaries are thickened, fibrotic or infiltrated. (Fig. 3.) They have lost their contractility and elasticity. The circulation in the skin is broken down, the metabolic processes are disturbed, and, therefore, the resistance to infection and trauma is highly diminished. Under this pathological condition, a slight injury, scratching, friction from hard

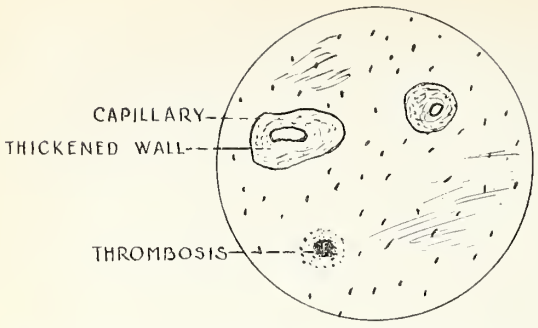


Fig. 3. *Note*—The capillaries have undergone the changes which are characteristic for the sclerosed surroundings. The capillaries are thickened, inviltrated, and thrombosed.

trousers, resulting from deposits of accumulated grease, etc.; infection due to poor hygiene, or local phlebitis are sufficient to destroy the skin and produce ulceration.

All ulcers have in common a diminished healing power, the tendency to recur and chronicity. The base of a varicose ulcer is covered with glossy, thin granulations which do not reach the surface. The edges, therefore, are abrupt, bluish, irregular, and infected.

The extreme degree of fibrosis is best realized when we try to penetrate the ulcer with a needle, in order to inject the blood. The resistance that is met feels as if we are penetrating through cartilage, or better yet, hard rubber. The ulcer is surrounded by a thick ring of fibrotic tissue, which shuts it off from the normal blood supply. It occurred to the author that breaking up this fibrotic ring, or sclerosed tissue surrounding the ulcer (lifting the ulcer from its bed) and injecting a fresh supply of nourishing material, as blood, is needed for the healing of these ulcers. This is accomplished by injecting patient's whole blood, in the ulcer, near the margin.

The Progress of the Ulcer after injection:

This permits formation of a new growth of granulation tissue. This tissue is comparatively cellular and very rich in young blood vessels. In the floor of the ulcer, where the injection has been given, new capillaries are formed from the pre-existing blood vessels, and they grow upward as vascular loops at right angles to the surface. (Fig. 4.) At their upper extremity, they have a coiled arrangement. Along with them there grow a large number of fibroblasts, (Fig. 5) which are, at first, mainly arranged parallel to the new capillaries.

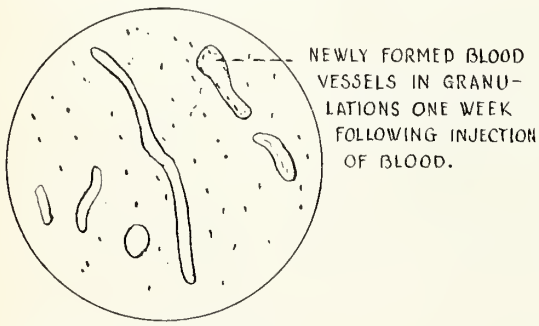


Fig. 4. Microscopic View.

Active emigration of leucocytes, chiefly polymorphonuclear, takes place from the new capillaries, especially in their upper part. These cells pass to the surface, where they play an important part in checking the growth of bacteria, thus allowing healing to progress. When there is little irritation from bacteria, the amount of exudation is relatively small, and is rich in leucocytes. Excessive irritation from continued bacterial growth gives rise to a more abundant, and more serous discharge, or there may even be a fibrinous exudate on the surface. Under these conditions, the growth of the young vascular tissue may be checked, part of it may become destroyed, and the process of healing will not be resumed satisfactorily until the bacteria have been destroyed by leucocytes and the sources of irritation and damage have thus been removed. The growth of the vascular tissue is directed to filling up the gap, and when this process has gone on for some time, the fibroblasts in the deeper part proceed to the formation of collagen fibrils, and in doing so arrange themselves more or less parallel to the surface, that is, at right angles to the vessels.

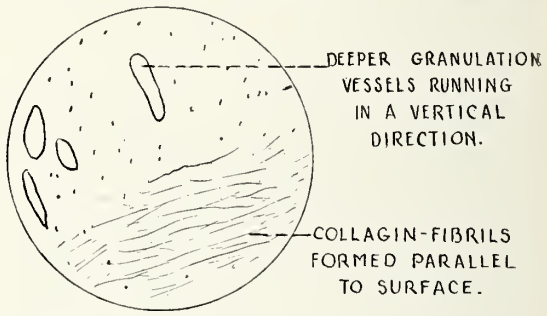
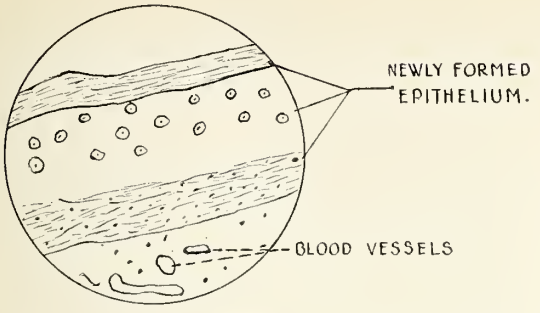


Fig. 5. Microscopic View.

Formation of Fibrous and Intercellular Tissue:

This formation proceeds from below upwards. When the gap has been sufficiently filled up, the cells of the epithelium at the margin begin to proliferate and grow over the young vascular tissue.

This occurs satisfactorily only when bacterial growth has been properly checked, chiefly by the action of the leucocytes. The first object of the epithelial cells is to cover in the surface. The growing epithelium is at first a thin layer of flattened cells (Fig. 6) (A & B) through which leucocytes are sometimes seen to be still passing. When the tissue has become completely covered by epithelium, emigration of polymorphonuclear leucocytes usually stops and these cells gradually



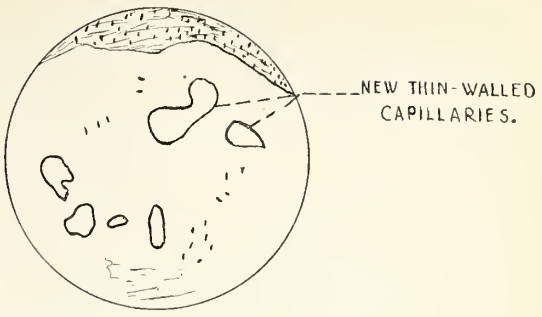


Fig. 6-A and Fig. 6-B. Microscopic Views.

disappear from the tissue. The leucocytes present are chiefly mononeuclear leucocytes, plasma cells and lymphocytes. The layer of epithelium thus formed then increases in depth and the cells become differentiated into the superficial cells of the stratum corneum and the rounded cells of the stratum malpighii. When the young tissue has been covered by epithelium, the growth of the blood vessels comes to an end, and a process of obliteration of the new vessels, or devascularisation sets in. This is accompanied by the formation of abundant collagen fibres, and ultimately the tissue becomes dense, fibrous, and is comparatively avascular, the characteristics of cicatrisation.

The Technique of Giving this Treatment:

Ulcers which are covered with dirty necrotic material and pus, and whose surrounding area is red and inflamed are first treated by a few days' rest in bed, and elevation. Local applications are made by the patient of warm, mild antiseptic wet dressing; e.g. saturated solution of boric acid, Burrow's solution, ¼ potassium permanganate 1/5000, sodium chloride, or magnesium sulphate, two tablespoonfuls to one quart of warm water. The applications are put on the ulcer, or ulcers, about three times a day, kept on for twenty minutes, each time.

As soon as the surface is fairly clean, I start with the injections. The ulcer and the edges surrounding the area is cleaned with alcohol. A 2 per cent Tr. Iodine solution is painted over the area, where the injection is given. A 10 cc. Luer syringe, with a 23 or 24 gauge needle, one to one and one-half inches in length, is employed. Blood is taken from cephalic, basilic, median cephalic or median basilic veins, at the bend of the elbow. About 10 cc. of blood is taken. Immediately after the blood has been drawn it is injected in the ulcer. (Fig. 7.) The injection is started one-fourth of an inch from the edge of the ulcer. The needle is inserted until it passes the resistant fibrotic area. The blood is slowly injected and continued while the needle is gradually withdrawn. Sometimes one injection is given at a sitting, or multiple injections up to four, have been given, at one-fourth to one-half inch intervals, depending upon the size of the ulcer. In the first treatment, the injections are started near the edges, and in the next treatment one-fourth inch nearer the center of the ulcer, etc. In some cases the entire circumference was injected. In the beginning this procedure is frequently painful, and it is advisable to anesthetize the ulcer with 2 per cent novocaine solution near the edges. This can be done in the first few treatments or for all the treatments. Considerable force will be found necessary in order to penetrate through the sclerosed area.

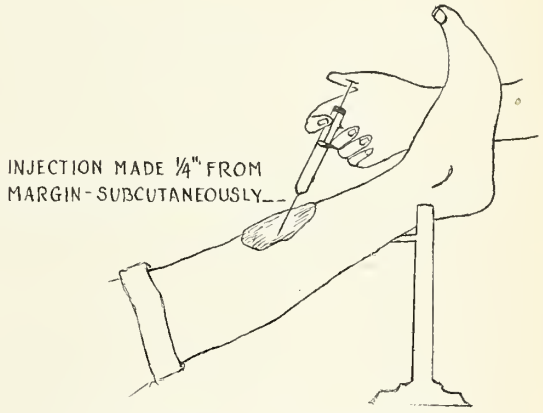


Fig. 7. Technique for injecting ulcer.

In the beginning of the treatment, very little bleeding will be noticed from the needle puncture, but after two or three treatments new blood vessels and granulations begin to form and bleeding becomes free. The treatment is repeated once a week until the ulcers show signs of healing, and then the injections are discontinued. The number of injections vary with the size and chronicity of the ulcer and with the extent of fibrosis in the surrounding area. The dressing should be made every two days. The ulcer is cleaned with alcohol, then dried, and mercurochrome, 2 per cent, applied, the latter having some astringent properties. The author has found, during the first two years of this work, that the ointment giving the best results, is gentian violet, 10 per cent, enough to cover the ulcer, being applied on gauze. Any excess of any ointment outside the ulcer area will

produce a dermatitis. During the last two years aqueous solution of gentian violet 5 per cent is applied to ulcer area instead of the ointment. In some cases, after the ulcer is healed, I advise patient to wear a supporting bandage for a few months. The healed scars of these ulcers following blood injections are very strong and do not break down easily.

Sloughs produced by some sclerosing solutions during the treatment of varicose veins are very difficult to heal. Pathogenesis of the sloughs is the same as in the ulcer. They are surrounded by a ring of fibrotic tissue, and the base is also fibrotic. When these sloughs are treated by injecting whole blood in the slough area, they heal very rapidly. The base should be injected, as well as the edges.

The clinical course of the healing of the ulcer appears as follows: The edges soften, bleeding from the needle puncture is free, and pink and healthy granulations appear at the base and edges. A seam of epithelium grows from the periphery towards the center of the ulcerated area. Sections taken from the healing ulcer show the base clean, free from necrotic material, the infiltration diminished, and rete pegs spreading over the edge. The most significant change takes place in the subpapillary capillaries. Normal vessels with a single row of endothelial lining appear, instead of the thrombosed infiltrated capillaries.

SUMMARY

Most of the chronic ulcers of the leg are caused by thrombosis and infiltration of the capillaries and stagnation in the smaller veins. A fibrotic ring surrounds the ulcer, and cuts it off from the normal blood supply, thus preventing healing.

Reasons for the blood injection method:

1. Injection of whole blood into the ulcer inside of margin, starting one-fourth inch from edge, through base of ulcer, raises the ulcer from its bed, breaking up the fibrotic ring, binding down the ulcer to its base, thus bringing in a fresh supply of blood.
2. Non-specific protein therapy.
3. The blood is in a better condition in the upper extremities, than in the lower extremities where stagnation is present.

This work was started in June, 1931, at St. Vincent Charity Hospital, Cleveland, Ohio. Since that time, 100 ulcer cases have come under my observation; 62 of these (35 females and 27 males) cases were cured with this method. The remaining 38 are still under observation. These latter are recent cases. Of the 62 cases cured, 47 were varicose ulcers and 15 were syphilitic ulcers. The varicose ulcer patients' ages range from 28 to 78. The Luetic ulcer patients' ages range from 25 to 69. Eighty per cent of the varicose ulcers were white; 80 per cent of the luetic ulcers were negro. Duration of both varicose and syphilitic ulcers treated were from one to 34 years. Two luetic ulcers had varicose veins, and these were injected with sodium morrhuate before blood was injected in ulcers.

In the present series of cases a history of definite preceding trauma was obtained in 65 per cent of the cases. The type of trauma varied somewhat, but appears usually to have been of more than usual severity. Some of the causes given by patients were: Sliver of wood; following scratching of a mosquito bite; a dog bite; a train wreck; auto wreck; striking a leg with a hatchet; falling against a hot furnace; spilling hot ashes on the leg; hit with a golf club. Two cases of varicose ulcers had a recurrence, which was evidently due to trauma. One had a varicose vein distal to ulcer which was found and injected and the ulcer healed. In the other a feeder was found proximal to the ulcer. It was injected, and another blood injection given in the ulcer, and it healed.

The number of injections given in the 47 cases of varicose ulcers:

Patients	Number of Injections
14	4
12	6
4	3
2	2
9	8
6	10

Luetic ulcers—15 cases:

My personal experience leads me to the conviction that anti-syphilitic treatment is by no means all that is required in the majority of cases. In those cases which occur in young individuals it may be rapidly and completely curative; but in older individuals in whom secondary changes have occurred in the blood vessels of the lower extremities, it may induce relatively little healing. Certainly, I cannot agree with those who think that vigorous anti-syphilitic treatment is specific, for these lesions and failure of the lesions to heal promptly under such therapy is an adequate reason for questioning the correctness of the diagnosis.

In the 15 cases, there were eight females and seven males.

The number of injections given in these cases:

Patients	Number of Injections
4	4
6	6
3	8
2	3

In five patients the Wassermann was positive. Ten patients received specific therapy. Whether the autogenous blood was an adjunct to specific therapy or actually healed the ulcer, I cannot say at present.

7713 EUCLID AVENUE.

OFFICIAL PROCEEDINGS OF THE HOUSE OF DELEGATES, OHIO STATE MEDICAL ASSOCIATION, 89TH ANNUAL MEETING, CINCINNATI, OCTOBER 2, 3 AND 4, 1935

MINUTES OF FIRST SESSION

THE 89th Annual Meeting of the Ohio State Medical Association opened officially in the Hall of Mirrors, Netherland Plaza, Cincinnati, at 1:00 P. M. Wednesday, October 2, 1935.

Edward D. King, president of the Cincinnati Academy of Medicine, called the meeting to order, officially welcomed the State Association to Cincinnati and presented John A. Caldwell, the President, who then took the chair and officially called the House of Delegates to order.

The first order of business was the roll call showing 86 delegates and officers present, this being a majority of those registered and constituting a quorum under the Constitution. (See tabulation of roll call attendance on pages 865 to 866).

On *motion* by Dr. DeWitt, seconded by Dr. Lukens and *carried*, the minutes of the House of Delegates of the 88th Annual Meeting held in Columbus, October 4, 5 and 6, 1934, were *approved* as published on pages 737-753 in the November, 1934, issue of *The Journal*.

President Caldwell called the attention of the delegates to the requirement that all resolutions must be introduced at the first session of the House of Delegates and referred to the Reference Committee on Resolutions which will report at the final session scheduled for Friday morning. He also announced that all resolutions must be in typewritten form, in duplicate and signed by the author.

ANNUAL REPORTS

The next order of business was the submission of annual reports of officers, standing committees and special committees published in full in the October, 1935, issue of *The Journal*. The following reports were submitted as published and referred without discussion to the Reference Committee on Annual Reports:

Reports of Standing Committees:

(a) Public Policy—J. H. J. Upham, Columbus, chairman, pages 764 to 769.

(b) Medical Economics—L. L. Bigelow, Columbus, chairman, pages 770 to 776.

(c) Medical Defense—J. E. Tuckerman, Cleveland, chairman, pages 776 and 777.

(d) Publication—Andrews Rogers, Columbus, chairman, pages 778 to 779.

(e) Medical Education and Hospitals—Ben R. McClellan, Xenia, chairman, pages 779 to 784.

(f) Auditing and Appropriations—B. J. Hein, Toledo, chairman, pages 790 to 793.

Reports of Special Committees:

(a) Preventive Medicine and Periodic Health Examinations—V. C. Rowland, Cleveland, chairman, pages 784 to 787.

(b) Military and Veterans' Affairs—Louis Feid, Jr., Cincinnati, chairman, pages 788 to 790.

Reports of Officers:

(a) Treasurer's report combined with report of Committee on Auditing and Appropriations, pages 790 to 793.

(b) Reports of Councilors as to the condition of the societies in their respective districts, pages 793 to 795.

HOUSE OF DELEGATES COMMITTEES

The President announced the appointment of the following reference committees of the House of Delegates:

Annual Addresses of the President and President-elect—C. W. Waggoner, Toledo, chairman; W. W. Sauer, Marietta; I. B. Harris, Columbus; Ralph H. Smith, Lancaster; R. D. Herlinger, Warren.

Annual Reports of Standing and Special Committees—J. E. Tuckerman, Cleveland, chairman; John A. Fraser, East Liverpool; L. Howard Schriver, Cincinnati; R. C. Paul, Wooster; Robert Conard, Wilmington.

Resolutions—J. Craig Bowman, Upper Sandusky, chairman; D. C. Houser, Urbana; Lester Taylor, Cleveland; Otto J. Seibert, Cincinnati; Sidney M. McCurdy, Youngstown.

Credentials of Delegates—D. J. Slosser, Defiance, chairman; Foster Kiser, Tippecanoe City; A. O. Peters, Dayton.

Tellers and Judges of Election—M. O. Cook, Hamilton, chairman; B. L. Good, Van Wert, G. G. Hunter, Ironton.

NOMINATING COMMITTEE

A Nominating Committee consisting of one delegate from each of the ten Councilor Districts as required by the Constitution, was elected by official vote of the House of Delegates. Members of the Nominating Committee from nine of the ten districts were selected by acclamation. In the Sixth Councilor District F. C. Potter, Akron, was nominated by Dr. Davidson, and Claude B. Norris, Youngstown, was nominated by Dr. McCurdy. By ballot the House of Delegates elected to the committee Dr. Potter, the vote being 37 to 33. The personnel of the committee as nominated and elected was as follows:

First District—Otto J. Seibert, Cincinnati, nominated by Dr. Swartz.

Second District—H. C. Messenger, Xenia, nominated by Dr. Hogue.

Third District—E. H. Porter, Tiffin, nominated by Dr. Firmin.

Fourth District—John F. Wright, Toledo, nominated by Dr. Lukens.

Fifth District—R. B. Wynkoop, Ashtabula, nominated by Dr. King.

Sixth District—F. C. Potter, Akron, nominated by Dr. Davidson.

Seventh District—W. L. Davis, Martins Ferry, nominated by Dr. Kirkland.

Eighth District—Geo. F. Swan, Cambridge, nominated by Dr. Brush.

Ninth District—C. F. Shonk, Logan, nominated by Dr. Brian.

Tenth District—John B. Alcorn, Columbus, nominated by Dr. Emerick.

The President appointed Dr. Seibert as temporary chairman of the Nominating Committee and instructed the committee to comply with the constitutional provisions by meeting and deciding upon one nominee for each of the offices to be filled at the 1935 Annual Meeting, except for the office of President-elect, which office is to be filled by nomination from the floor at the Friday morning session.

INTRODUCTION OF RESOLUTIONS

Under the next order of business, President Caldwell called for the introduction of resolutions.

The following resolutions were introduced and referred to the Committee on Resolutions for consideration and report at the second session of the House of Delegates on Friday morning, October 4:

Resolution A. Introduced by D. W. Hogue, Springfield:

WHEREAS, A special session of the Ohio General Assembly will be held in the near future, and,

WHEREAS, It is anticipated the General Assembly will be called upon to consider proposals relating to taxation, workmen's compensation, and social insurance, including perhaps, compulsory sickness insurance;

THEREFORE BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association urges all members to give this important session of the State Legislature their immediate and serious consideration and take an active part in the legislative activities of this Association in safeguarding the interests of the medical profession, individually and collectively, and,

BE IT FURTHER RESOLVED, That this Association expresses its opposition to the enactment of measures providing for the levy of unjust or discriminatory taxes on physicians, and,

BE IT FURTHER RESOLVED, That this Association reaffirms its present policies opposing proposals providing for the establishment of a compulsory sickness insurance system and measures which, if enacted would weaken the structure of the Ohio Workmen's Compensation Act and lead to administrative difficulties, and,

BE IT FURTHER RESOLVED, That the Committee on Public Policy is herewith requested to take the necessary steps to apprise the members of the State Legislature with the viewpoints of organized medicine on these important questions and to call upon all members of this Association for their active assistance and cooperation in meeting this critical situation.

Resolution B. Introduced by C. G. LaRocco, Cleveland:

WHEREAS, The problem of pollution of streams increasingly presents aspects of the greatest importance to the health of the people, over wide regions, often including a number of states;

BE IT RESOLVED, That the Ohio State Medical Association strongly favors a unified control of health activities related to abatement of stream pollution, recommending as the most suitable agency for coping with this regional and interstate problem the United States Public Health Service;

BE IT FURTHER RESOLVED, That the Ohio State Medical Association request the Ohio delegation in the United States Senate and House of Representatives to lend its efforts to bring about the establishment of such unified control.

Resolution C. Introduced by Claude B. Norris, Youngstown:

A resolution to provide for a lien for the value of services rendered by any physician, dentist, nurse, or hospital in the treatment or care of any person injured through the fault or neglect of another; to define the manner of perfecting such lien and providing to what it shall attach and the liability thereon.

WHEREAS, The economic welfare of the Medical Profession is undergoing great changes and the financial condition of physicians is becoming precarious; and

WHEREAS, The State of Ohio recently passed legislation intending to protect its citizens against damage caused by automobiles; and

WHEREAS, Duty makes it obligatory that the medical profession care for such accidents, and in the past the physicians have sustained great losses by reason of this; and

WHEREAS, Fifteen states have already seen fit to pass lien laws to protect the fees of physicians or hospitals or both in cases of accidents not satisfactorily covered by State Compensation Laws.

THEREFORE BE IT RESOLVED, That we, the members of the House of Delegates of the Ohio State Medical Association, now in session, instruct the committee on Public Policy to act as follows:

(1) To co-operate with suitable committees of the Ohio Hospital Association, the Ohio Nurses' Association, and the Ohio Dental Association, concerning the framing of a new lien law; this new lien law to be presented at the next session of the Legislature for enactment, that thereby the members of these Associations may be protected in respect to their fees in all accidents now covered by State Insurance.

(2) That the model bill prepared by The American Medical Association shall be used for guidance as well as the best features of bills already enacted in other states.

Resolution D. Introduced by F. C. Potter, Akron:

BE IT RESOLVED, That the House of Delegates requests The Council of the Ohio State Medical Association to consider the possibility and advisability of establishing a Speakers' Bureau to be operated by the State Association for the pur-

pose of providing county and district medical societies with speakers, on request, and in other ways promoting the post-graduate educational activities of the State Association, and

BE IT FURTHER RESOLVED, If upon thorough investigation, the organization of a Speakers' Bureau is found feasible and practicable, The Council take the necessary steps to establish it and appropriate sufficient funds for its operation under rules and regulations promulgated by The Council.

Resolution E. Introduced by John A. Fraser, East Liverpool:

WHEREAS, Plans are being made by the State Department of Health to extend and improve maternal and child health services and other public health services in Ohio in accordance with the provisions of the Federal Social Security Act, and,

WHEREAS, Representation from the Ohio State Medical Association on an official advisory council to assist in the administration of the public health activities of the Social Security Program in Ohio has been requested by the State Director of Health,

BE IT RESOLVED, That this Association expresses appreciation for this invitation to assist and advise in the administration of these activities, and,

BE IT RESOLVED, That those charged with administration of the public health activities of the Society Security Program in Ohio respectfully be requested to frequently confer with officials of the Ohio State Medical Association on matters of policy and procedure to avoid, if possible, misunderstandings and conflicts, and with officials of component county medical societies on local activities.

BE IT RESOLVED, That the physicians of Ohio individually and collectively be urged to assist and cooperate in the furtherance of this program providing its provisions conform to the fundamental policies approved and adopted by the House of Delegates of the Ohio State Medical Association.

Resolution F. Introduced by J. M. Firmin, Findlay:

WHEREAS, It has been noted with disappointment that some of the graduates of medical schools and colleges in recent years apparently are unfamiliar with the objectives and activities of organized medicine and lack a clear understanding of the benefits to be derived through membership in local, state and national medical societies; and,

BE IT RESOLVED, By the House of Delegates of the Ohio State Medical Association, October 2-4, 1935, that the administrative officials of all accredited American medical colleges be respectfully requested to provide instruction for senior students on the activities, services, and benefits of organized medicine.

BE IT RESOLVED, That a copy of this resolution be transmitted to the dean of each of the accredited medical colleges of America, the Council on Medical Education and Hospitals and the Board of Trustees of the American Medical Association, and the secretary of each constituent state medical society.

Resolution G. Introduced by B. J. Hein, Toledo:

BE IT RESOLVED, By the House of Delegates of the Ohio State Medical Association, on behalf of the medical profession of Ohio, that:

The State Industrial Commission respectfully be requested to give its immediate consideration to rescinding the 20 per cent reduction of medical and surgical fees of physicians for services to beneficiaries of the Workmen's Compensation Law.

The Ohio State Medical Association re-affirms its opposition to any changes in the Ohio Workmen's Compensation System which would modify the fundamental purposes of the compensation law; be detrimental to efficient administration procedure; or mitigate against the best interests of disabled workers.

This association offers its active assistance in efforts to secure from the General Assembly adequate appropriations for operation of the State Industrial Commission.

Organized medicine reiterates its appreciation of the cooperative attitude displayed in the past by the State Industrial Commission; expresses confidence in the integrity and ability of the Commission to administer the compensation law for the best interests of all concerned; and pledges its active support to the Commission in improving administration of the Workmen's Compensation Law.

Resolution H. Introduced by H. V. Dutrow, Dayton:

WHEREAS, It is well known that deafness in a certain, large percentage of cases can be prevented and in many cases can be ameliorated; and since deafness is a widespread affection, there being three million school children in this country who are hard of hearing; and since other state societies have already established committees for the prevention and amelioration of deafness; furthermore since it is necessary that the medical profession, particularly those engaged in the practice of Otology, should make every effort to take part in an educational program which will aid in the prevention and amelioration of deafness;

BE IT RESOLVED, THEREFORE, That the Ohio State Medical Association empower its President to appoint a permanent committee of five members to be called "The Committee on Prevention and Amelioration of Deafness." The purpose of this committee shall be to acquaint the physician and the public with the problems of impaired hearing, to promote the periodic, scientific examination of the hearing acuity of all school children, to protect the hard of hearing from charlatans and to cooperate with the local and national agencies engaged in improving the conditions of the hard of hearing, and

BE IT FURTHER RESOLVED, That this committee be empowered to add to its membership from time to time as ex-officio members persons other than members of this society who are especially interested and are working along these lines.

There being no further business following the introduction of resolutions, the House of Delegates adjourned to meet in the Hall of Mirrors, Netherland Plaza, at 9:00 A. M., Friday, October 4, 1935.

MINUTES OF SECOND SESSION

The second and final session of the House of Delegates during the 89th Annual Meeting was called to order by President Caldwell at 9:00 A. M., Friday, October 4, 1935, in the Hall of Mirrors, Netherland Plaza, Cincinnati. Responses to

the roll call showed 84 delegates and officers present. (See pages 865 to 866).

AMENDMENTS TO BY-LAWS

Under the order of business of unfinished business, Dr. Upham presented for the consideration of the House of Delegates the following proposed amendments to the By-Laws of the State Association, which proposed amendments had been published in *The Journal*, September, 1935, issue, page 693, in compliance with Chapter XIII, Section 1, of the By-Laws:

Proposed Amendment No. 1

That Chapter 8, Section 4, of the By-Laws relating to the collective duties of the Council, be supplemented as follows:

"The Council shall provide for and superintend the issuance of *The Ohio State Medical Journal*. It shall have authority to appoint a medical editor or publication board or committee, or both, and make any other provisions for publication of *The Journal* which in its judgment are feasible and practical. Such appointee or appointees shall serve at the pleasure of the Council, which shall have full discretionary power to promulgate rules and regulations governing the publication of *The Journal;* enumerate the powers and duties of the medical editor or publication board or committee, or both; and fix the terms and conditions of his or their appointment."

Proposed Amendment No. 2

That Chapter 9, Section 1 of the By-Laws be amended by deleting the line reading:

"2. A Committee on Publication", and renumbering the succeeding lines of the section.

Proposed Amendment No. 3

That Chapter 9, Section 3 of the By-Laws be deleted and the succeeding section numbers be renumbered "3", "4", "5" and "6", respectively.

Dr. Upham, speaking in favor of the amendments, pointed out that the present inflexible provisions of the By-Laws handicapped the Publication Committee, limited the scope of its work, and prevented the inauguration of innovations which would increase the usefulness and value of *The Journal*. He stated that elimination of the specific provisions governing the publication of *The Journal* and delegation of this authority to the Council would permit the Council to establish a more extensive and more elastic set-up for publishing *The Journal* and allow the combination of various suggested methods. Dr. Upham said that publication questions had been discussed by the Special Committee on Extension of Activities appointed last Spring to recommend ways the State Association can extend its services and increase its benefits to the members and that the foregoing amendments had been suggested and agreed upon by that committee during its deliberations.

On *motion* by Dr. Upham, seconded by Dr. Tuckerman and *carried*, the foregoing amendments to the By-Laws were *adopted*.

TIME AND PLACE OF NEXT ANNUAL MEETING

By unanimous consent of the House of Delegates, President Caldwell changed the order of business and at this time called for the selection of the time and place for the 1936 Annual Meeting of the State Association.

Dr. Jenkins, on behalf of the Cleveland Academy of Medicine, invited the State Association to hold its 1936 meeting in Cleveland.

Dr. Grierson, on behalf of the Erie County Medical Society, invited the State Association to meet at Cedar Point in 1936. A *motion* by Dr. Lukens, seconded by Dr. Loebell, that Cleveland be selected as the place for the next Annual Meeting was amended by a *motion* by Dr. Wright, seconded by Dr. Grierson, and *carried*, that the House of Delegates select the 1936 meeting place by ballot, each delegate to indicate his choice between Cleveland and Cedar Point. The *motion as amended* was *adopted* by acclamation. On the first ballot, Cleveland was selected as the place for the 1936 meeting, the official vote being 45 to 33.

It was *moved* by Dr. Lukens, seconded by Dr. Swan, that the State Association hold its 1936 meeting in the Spring. Following prolonged discussion as to whether the next meeting should be held in the Spring or in the Fall, the original motion was amended on *motion* by Dr. Ratliff, seconded by Dr. Upham and *carried* to read that the question as to when the 1936 meeting should be held should be submitted by mail to the respective component county medical societies. The *motion as amended* was *adopted* by acclamation, the understanding being that the State Headquarters Office would immediately secure from each component county society an official expression as to when the 1936 Annual Meeting should be held and that the Council should set the time in accordance with the majority opinion obtained through such referendum.

ANNUAL ELECTION

The House of Delegates then reverted to the third order of business, being the election of a President-elect.

Nominations having been called for, D. C. Houser, Urbana, placed in nomination the name of E. M. Huston, Dayton. The nomination was seconded by Dr. Upham.

Further nominations being called for and none being presented, on *motion* by Dr. Dutrow, seconded by Dr. Davidson and *carried*, the nominations were closed, and the secretary was instructed to cast the unanimous ballot of the House of Delegates for E. M. Huston, Dayton, as President-elect of the State Association. *So recorded and announced.*

ELECTION OF COUNCILORS

At this point the Nominating Committee, through its chairman, John F. Wright, Toledo, reported nominees for the office of Councilor from the Second, Fourth, Sixth, Eighth and Tenth Councilor Districts.

Second District Councilor Election

The Nominating Commitee announced the following nomination for Councilor from the Second District—D. W. Hogue, Springfield, to succeed E. M. Huston, elected to the office of President-elect.

There being no nominations from the floor, on *motion* by Dr. Alcorn, seconded by Dr. Cummer and *carried*, the secretary was instructed to cast the unanimous ballot of the House of Delegates for D. W. Hogue as Councilor of the Second District for the constitutional term of two years. *So recorded and announced.*

Fourth District Councilor Election

The Nominating Committee announced the following nomination for Councilor from the Fourth District—B. J. Hein, Toledo.

There being no nominations from the floor, on *motion* by Dr. Tuckerman, seconded by Dr. Ratliff and *carried*, the secretary was instructed to cast the unanimous ballot of the House of Delegates for B. J. Hein as Councilor of the Fourth District for the constitutional term of two years. *So recorded and announced.*

Sixth District Councilor Election

The Nominating Committee announced the following nomination for Councilor from the Sixth District—H. S. Davidson, Akron.

The name of Wm. M. Skipp, Youngstown, was placed in nomination by Dr. McCurdy, and such nomination was seconded by Dr. Steinke.

Further nominations being called for and none being presented, on *motion* by Dr. Ratliff, seconded by Dr. Loebell and *carried*, the nominations were closed, and the Committee on Tellers and Judges of Election were requested by the President to distribute ballots. The ballots were tabulated and showed the following result:

Dr. Skipp, 49 votes.

Dr. Davidson, 34 votes.

On the basis of the above vote, the President declared Dr. Skipp officially elected by the House of Delegates as Councilor of the Sixth District for the constitutional term of two years. *So recorded and announced.*

Eighth District Councilor Election

The Nominating Committee announced the following nomination for Councilor from the Eighth District—E. R. Brush, Zanesville.

There being no nominations from the floor, on *motion* by Dr. Jenkins, seconded by Dr. Thomas and *carried*, the secretary was instructed to cast the unanimous ballot of the House of Delegates for E. R. Brush as Councilor of the Eighth District for the constitutional term of two years. *So recorded and announced.*

Tenth District Councilor Election

The Nominating Committee announced the following nomination for Councilor from the Tenth District—C. C. Sherburne, Columbus.

There being no nominations from the floor, on *motion* by Dr. Hogue, seconded by Dr. Alcorn and *carried*, the secretary was instructed to cast the unanimous ballot of the House of Delegates for C. C. Sherburne, as Councilor of the Tenth District for the constitutional term of two years. *So recorded and announced.*

ELECTION OF A. M. A. DELEGATES

The Nominating Committee announced the nomination of the following delegates and alternates to the American Medical Association for a term of two years.

J. P. DeWitt, Canton, Delegate.
G. F. Zinninger, Canton, Alternate.
C. E. Kiely, Cincinnati, Delegate.
L. H. Schriver, Cincinnati, Alternate.
C. W. Waggoner, Toledo, Delegate.
Charles Lukens, Toledo, Alternate.

There being no nominations from the floor, on *motion* by Dr. Seibert, seconded by Dr. Swartz and *carried*, the secretary was instructed to cast the unanimous ballot of the House of Delegates for the foregoing nominations made by the Nominating Committee. *So recorded and announced*

INTRODUCTION OF NEW PRESIDENT-ELECT

At this point a committee escorted E. M. Huston, newly-elected President-elect to the rostrum and he was officially presented to the House of Delegates. Dr. Huston voiced his deep appreciation for the honor bestowed upon him and expressed the hope that he would receive the full support and cooperation of all members of the Association during his administration, which he said he hoped would be as successful as those in recent years.

REPORTS OF REFERENCE COMMITTEES

The reports of the various reference committees appointed by the President at the first session were called for.

Annual Addresses

C. W. Waggoner, Toledo, chairman of the Committee on Annual Addresses of the President and President-elect, presented the following report, signed by him, Ralph H. Smith, Lancaster, and I. B. Harris, Columbus:

The Address of Dr. R. R. Hendershott.

Your committee has had a pleasant opportunity to listen to the address of Dr. R. R. Hendershott, Tiffin, Ohio.

We think that Dr. Hendershott is rather modest in alibing his duty to the mandatory provisions of the Constitution, and not claiming some of the credit due himself because of his oratorical ability and physical charm. Nevertheless, in a broad comprehensive review of the last 100 years of the Ohio State Medical Association and of its accomplishments, we realize how profoundly interested and enthusiastic Dr. Hendershott is in trying to present before not only the members of the organization but to the lay public, the principles and the practices and the subjects that lie within the activities of this great State Association.

Dr. Hendershott has picked out leaders of the past, and used their excellent advice, as he quotes them to you, for furthering loyalty, wholesomeness, and interest in the practice of the art and science in medicine.

Dr. Hendershott points out the hazards that may be produced by the disloyal, by unethical practice, by the failure to follow the traditions and rules laid down in the past by very worthy doctors of medicine, emphasizing as he does that inasmuch as the organization of medicine has made it possible for doctors to become what they really are, the really most unworthy act a doctor can do is to be disloyal to his organization.

Officers must be selected with care and the different committees in the county societies must have a proper personnel, then these in turn, as well as every individual doctor, must see that the right kind of men belong to the society, and men who do not live up to the principles enunciated by the American Medical Association, carried through to the State Association, then to the county societies, must be disciplined, or eliminated from organized medicine. We must always bear in mind that organized medicine can exist without these few men but these few men need badly an organization to protect them.

We find one of the great weaknesses in the activities of county societies is the selection of delegates to the State Association. Many times men are sent as delegates who are not interested and insist on criticizing activities which they know nothing about. As pointed out in Dr. Hendershott's address, the county society's duty, as in the past, is to play a very active role in community life. It must be educational from the point of economic interest and guide public opinion on medical and public health matters.

The county society should be sufficiently strong to guide and direct certain legislative activities both in the community and in the state.

Dr. Hendershott points out and we quote: "Obviously we should have little patience with those who habitually wink at professional ethics and engage in dishonorable practices. Medical organization does not need members of this type and is derelict in its obligations to the public if it refrains from initiating disciplinary actions against them."

Dr. Hendershott points out, and your committee thinks it true, that those who are about to carry on where others left off will be confronted with a difficult problem unless they have had training by the ones who are familiar with the activities of organized medicine. So it becomes a very definite suggestion that the younger men be trained by the constant association with the older men in organization work.

In the addresses of Dr. Caldwell and Dr. Hendershott we find little, if anything, concerning the economics of medicine. While this committee realizes that the profession as a whole has heard discussions of this subject for years, and perhaps more or less intensively of late, yet we feel that the economics of medicine and constant consideration of these problems should be kept as a live subject before the doctor. Therefore, we think we would be negligent in our duty if we did not bring this to your attention so that you might at least realize that this is still a pressing matter and that your state organization is very active and vitally concerned with such measures.

The Industrial Commission of Ohio has had its many problems and we think that we must all appreciate the constructive work our Association has done in its effort to maintain a standard of industrial fees.

Government relief work: While your committee regards the work of taking care of the sick under government control and pay as a laudable and necessary activity, we must constantly keep in mind that many individuals on the "dole", become students of evasion of responsibility and apostles of destruction of individuality.

I think we can best close this comment on Dr. Hendershott's paper by the quotation he uses in closing his address.

"If you work in a profession, in Heaven's name work for it. If you live by a profession, live for it. Help advance your co-worker. Respect the great power that protects you, that surrounds you with the advantages of organization, and that makes it possible for you to achieve results. Speak well for it. Stand for it. Stand for its professional supremacy. If you must obstruct or decry those who strive to help, why—quit the profession. But as long as you are a part of a profession, do not belittle it."

On *motion* by Dr. Waggoner, seconded by Dr. Wright and *carried*, the House of Delegates *approved* that portion of the report dealing with the address of the President-elect.

The Address of Dr. John A. Caldwell.

Your Committee on Presidential Addresses has had the opportunity to hear the address of Dr. John A. Caldwell, Cincinnati, Ohio, the Retiring President.

At this meeting of the Ohio State Medical Association, marking as it does the 100th anniversary of the first meeting in Ohio of this Association, it is only proper that Dr. Caldwell also should pay tribute to the founders and point out the work that these men did from time on, using this work and these sacrifices as an example for the present generation to exemplify and follow.

Dr. Caldwell furthers this example by pointing out the necessity for individual work by the doctors in the practice of medicine although they may not hold office and they may not aspire to hold office, yet their duty is just as great and definite as those who do hold office.

Dr. Caldwell also points out the necessity of cooperation with the state headquarters, a sympathetic understanding between the two elements so that harmony may increase the effect of the force utilized.

It becomes necessary here to realize that every department of the State Association must be cooperative, must be enthusiastic, and in that way will be helpful. The more we realize that the Ohio State Medical Association is a democratic association in which everyone has an opportunity to express himself, the more we will get out of our minds the idea that just a few are running this Association. While this at times may seem true, yet an analysis will show that anyone who shows sufficient interest in his local or state affairs always has an opportunity to become just as active as he desires.

This brings us to a very important consideration in men who become active in organization work.

Many mistakes have been made by men who have been trained from the less significant office in his county organization to the highest in the state, but again, analyzing the situation, we find that the great mistakes have been made by the men who had no training in minor office and sud-

denly were placed in positions of responsibility without knowing what it was all about.

Dr. Caldwell rightly stresses the activity of Council. Little do men generally know of the detailed activity of this body unless they have been members for some time. The many subjects that come up for discussion, the many problems for solution, and the great responsibility the Council has only can be realized by study of Council's activities.

Dr. Caldwell suggests that when it becomes necessary for the better protection of the individual members of the Association, the Constitution and By-Laws should be changed. This is a progressive body, and, therefore, can not be expected to operate under designations that are obsolete. Your committee endorses fully the suggestion that a committee be appointed to study the Constitution and By-Laws and report changes deemed advisable to further facilitate activities.

The question of public health has always been a problem. Your committee feels as men have always felt in the past, that the activities of public health should be controlled by the Ohio State Medical Association, that its effectiveness and harmonious operation depend upon a thorough understanding between the official bodies and the private practitioner.

In closing a discussion of Dr. Caldwell's address, we can say that it is comprehensive, to the point, very fair, and does credit to a year of activity which Dr. Caldwell has just closed.

On *motion* by Dr. Alcorn, seconded by Dr. Grierson and *carried*, the House of Delegates *approved* that portion of the committee's report dealing with the address of the Retiring President, and the report as a whole.

Annual Reports

J. E. Tuckerman, Cleveland, chairman of the Reference Committee on Annual Reports, presented the following report, signed by him and R. C. Paul, Wooster, Robert Conard, Wilmington, and L. Howard Schriver, Cincinnati:

To the House of Delegates, Ohio State Medical Association:

According to custom the President has designated a Committee on Annual Reports. It is the duty of this committee to review the reports of standing and special committees and the annual report of the Council and to bring to the attention of the House of Delegates such matters as seem to them in need of special consideration.

The reports of committees as published in *The Journal* constitute a brief summary of their activities and a statement of policy on matters handled.

1. Annual Report of the *Committee on Medical Defense.*

This report points out that malpractice suits are not to be considered in the same light as civil suits which can properly be adjusted by cash settlements; re-states the purpose of the medical defense plan and the requirements for its application; and points out that it is not part of a physician's obligation to perfect malpractice suits for his patients.

2. Annual Report of the *Committee on Military and Veterans' Affairs.*

This committee's report calls attention to the opportunities for appointment as first lieutenants open to graduates of Class A schools; strongly urges physicians of military age who have had previous experience to avail themselves of the opportunities for practical training and the commissions offered in the Organized Medical Reserve Corps and the Ohio National Guard; and re-states its belief that the federal government should continue its present policy of not erecting new hospitals for the care of veterans, inasmuch as present facilities are quite adequate to meet the needs.

3. Annual Report of the *Committee on Medical Education and Hospitals.*

In the stress of economic problems we must not forget the necessity for continuous study in the field of scientific medicine. The report states the desirability of county societies becoming the agent of postgraduate education; outlines the facilities for graduate study; and comments on the high standing of Ohio's three Class A medical colleges. It suggests the necessity for more adequate training of students in the economics of medicine and calls attention to the obligation of physicians to assist hospitals in solving their financial problems, advising the reduction of their capital indebtedness and against ill-considered expansion of capacity.

4. Annual Report of the *Committee on Preventive Medicine and Periodic Health Examinations.*

The report rightly states that the stereotyped physical examination is but a beginning in the application of a periodic health examination. Preventive health interviews should follow and these must of necessity be private in nature. Preventive medicine can be applied all through private practice; tactful personal interest can prevent neuroses; and hygienic control avoid those factors which precipitate functional and mental disorders. The report calls for increased cooperation with public health officials; cites the advantages to be gained from an industrial bureau such as obtains in Connecticut and suggests the desirability of a like provision in Ohio. In particular, it points out the opportunity of private physicians in the immunization against diphtheria of children under the age of one year, and that there is a large field for health activity on the part of the private physician among children between the age at which they attend the infant clinics and come in contact with school health services.

5. Annual Report of the *Committee on Public Policy.*

The report of this committee emphasizes anew urgent problems which confront the medical profession. Its activities have been varied and largely concerned with legislation and governmental administration, detailed accounts of which have, from time to time, been published in *The Journal.* The committee obtained very satisfactory action on legislation during the 91st General Assembly. None-the-less attention is called to the special session of the State Legislature at which a tax on professional and non-professional services and compulsory state health insurance may be brought up. The committee needs the active support of every member and of every county society at this time. Because of the uncertainty about the future of poor relief activities in Ohio, the committee urges that every county medical society form a strong medical advisory committee in cooperation with the individuals responsible for relief in the respective counties. It points out the danger of minimum fee schedules and is par-

ticularly opposed to the insertion in poor relief statutes of a definite state-wide medical fee schedule governing physicians' services to the indigent or reference to fee schedules established by administrative order.

The committee is definitely of the opinion that local subdivisions should be charged with the responsibility for medical care of recipients of old age pensions, as provided in present statutes on relief, providing such pensioners cannot make adequate arrangements with the family physicians. It has continued its policy of maintaining contact with allied professional groups and industrial and business organizations and emphasizes the necessity for greater public activity on the part of medical organization and physicians as individuals. The problems confronting the medical profession must be met by concerted action on the part of the local medical societies and the public must be accurately and fully informed on the medical viewpoint on the social and economic aspects of medical service.

6. Annual Report of the *Committee on Medical Economics.*

The reference committee is in accord with the views expressed in this report. Most physicians are not fully informed upon critical problems confronting the medical profession, largely because they neglect to read authentic data disseminated to them through the channels of organized medicine. The report is an excellent guide to the authentic literature upon the economic and social aspects of medical practice. The committee does not commit itself to any one solution believing that the final decision must rest with the component societies who are in touch with local conditions. It points out the danger that voluntary health insurance plans may become compulsory; that needed medical services cannot be properly dispensed by mass production methods, but that the proponents of such methods are neither satisfied nor discouraged and that they will continue their campaign of propaganda and pressure; and that every physician must realize that the public opinion makes and unmakes laws and the responsibility for molding public opinion on medical questions rests on the shoulders of the medical profession.

7. Annual Report of the *Council.*

The report of the Councilors notes the problems confronting the profession are becoming increasingly difficult, and particularly urges that every county society should have an alert and aggressive Public Relations Committee and every member should be made to feel it is an obligation on his part to give this committee full support and cooperation; that every member read carefully, if he has not already done so, the minutes of the Council meetings held during the year inasmuch as they are an official resume of many of the important activities of organized medicine in Ohio for the past year; and that closer contact be maintained during the coming year between the Council and the various county medical societies and between the individual members of the Council and the members of the different districts.

8. Annual Report of the *Committee on Auditing and Appropriations.*

This report shows the financial position of the Association to be satisfactory. Your reference committee is in accord with the statement that the Ohio State Medical Association at present offers more services and relatively greater benefits to the members in proportion to the annual dues than any other state medical association and probably any other professional or business organization. The State Association must protect the interests of the profession and the public. Extension of essential activities and services will call for additional expenditures and may call for increased revenues.

9. Annual Report of the *Publication Committee.*

In reading this report one thinks back with amazement to the time when there were those who thought a state medical journal a needless adjunct to an annual meeting. The committee is to be commended for the manner in which it has made *The Journal* increasingly indispensable to the state organization, and for its insistence on scientific value and literary merit in the articles accepted for publication and for its policy in carrying information on social, economic and governmental questions.

Were each member to read from cover to cover each number of *The Journal*, no one would have occasion to ask, "What does the Association do for me?" and the report of a Committee on Annual Reports would cease to be even of passing moment.

On *motion* by Dr. Tuckerman, seconded by Dr. Emerick and *carried*, the reference committee's report on annual reports was *approved and adopted.*

Report of Committee on Resolutions

The following report of the Reference Committee on Resolutions was presented by J. Craig Bowman, Upper Sandusky, chairman, and signed by Dr. Bowman, D. C. Houser, Urbana, Otto J. Seibert, Cincinnati, and Sidney McCurdy, Youngstown:

To the House of Delegates, Ohio State Medical Association, 89th Annual Meeting, Cincinnati, Ohio:

The Reference Committee on Resolutions, consisting of D. C. Houser, Urbana, Lester Taylor, Cleveland, Otto J. Seibert, Cincinnati, Sidney McCurdy, Youngstown, and J. Craig Bowman, chairman, Upper Sandusky, held several meetings and has given thorough consideration to the resolutions introduced at the first session of the House of Delegates held Wednesday afternoon, October 2. The committee has consulted with members interested in the questions covered by the various resolutions and after due deliberation submits for the consideration of the House of Delegates the following comments and recommendations:

Resolution A

Resolution A, introduced by D. W. Hogue, Springfield, reading as follows, meets with the hearty approval of this committee, which, therefore, recommends its adoption:

WHEREAS, A special session of the Ohio General Assembly will be held in the near future, and,

WHEREAS, It is anticipated the General Assembly will be called upon to consider proposals relating to taxation, workmen's compensation, and social insurance, including perhaps, compulsory sickness insurance;

THEREFORE BE IT RESOLVED, That the House of Delegates of the Ohio State Medical Association urges all members to give this important session of the State Legislature their immediate and serious consideration and take an active part in the legislative activities of this Association in safeguarding the interests of the medical profession, individually and collectively, and,

BE IT FURTHER RESOLVED, That this Association expresses its opposition to the enactment of measures providing for the levy of unjust or discriminatory taxes on physicians, and,

BE IT FURTHER RESOLVED, That this Association reaffirms its present policies opposing proposals providing for the establishment of a compulsory sickness insurance system and measures which, if enacted would weaken the structure of the Ohio Workmen's Compensation Act and lead to administrative difficulties, and,

BE IT FURTHER RESOLVED, That the Committee on Public Policy is herewith requested to take the necessary steps to apprise the members of the State Legislature with the viewpoints of organized medicine on these important questions and to call upon all members of this Association for their active assistance and cooperation in meeting this critical situation.

On *motion* by Dr. Bowman, seconded by Dr. Alcorn and *carried*, the reference committee's report on Resolution A was *adopted*.

Resolution B

Resolution B, introduced by C. G. LaRocco, Cleveland, emphasizes the serious problem of stream pollution from the standpoint of public health and seeks to have the Ohio State Medical Association officially advocate the unification of control and abatement of stream pollution under the U. S. Public Health Service.

This resolution is in line with the comments made by President Caldwell in his presidential address on Wednesday evening. Your committee realizes the seriousness of this national public health question. It believes that the medical profession and medical organization should give their united support to constructive efforts to cope with this health menace.

However, we are of the opinion that a study should be made of this question for the purpose of securing additional information and data before the Ohio State Medical Association officially supports any one method or set-up for attacking this problem.

Therefore, it is recommended by your committee that the House of Delegates defer action on Resolution B and refer it to the Committee on Public Policy of the State Association with the suggestion that such committee initiate a study of the question and in due time report to the Council of the State Association, which may take such action as is deemed advisable.

On *motion* by Dr. Seibert, seconded by Dr. Potter and *carried*, the reference committee's report on Resolution B was *adopted*.

Resolution C

Resolution C, introduced by Claude B. Norris, Youngstown, has been slightly modified by this committee, which recommends its adoption as follows:

WHEREAS, The economic welfare of the medical profession is undergoing great changes and the financial condition of physicians is becoming precarious; and

WHEREAS, The State of Ohio recently passed legislation intending to protect its citizens against damage caused by automobiles; and

WHEREAS, Duty makes it obligatory that the medical profession care for persons disabled in accidents of all types, and in the past physicians have sustained great losses by being unable to collect fees for such services, and

WHEREAS, Fifteen states have already seen fit to pass lien laws to protect the fees of physicians or hospitals or both in cases of accidents; therefore be it

RESOLVED, That we, the members of the House of Delegates of the Ohio State Medical Association, now in session, instruct the Committee on Public Policy to act as follows:

(1) To make a thorough study of the advisability of having introduced in the next regular session of the Ohio General Assembly in 1937 a proposal providing for a lien for the value of services rendered by physicians, dentists, nurses and hospitals in the treatment or care of persons injured through the fault or neglect of another.

(2) To confer with the proper officers of official organizations representing groups which may be interested in such a proposal.

(3) To consult officials of the American Medical Association and secure information for guidance on this matter. Also to obtain pertinent information from the officials of the state medical societies in states where a lien law is now in effect.

(4) To prepare a report and recommendations at the conclusion of its study and submit them to the House of Delegates of the Ohio State Medical Association for official action at its session in 1936.

On *motion* by Dr. Bowman, seconded by Dr. Steinke and *carried*, the reference committee's report on Resolution C was *adopted*.

Resolution D

Resolution D, introduced by F. C. Potter, Akron, has the hearty approval of the Reference Committee on Resolutions, which recommends its adoption with slight amendments and changes in construction, as follows:

WHEREAS, It is important that the Ohio State Medical Association cooperate with and assist county and district medical societies in securing qualified and well-informed speakers to promote postgraduate educational activities and to keep the membership accurately informed on all questions of direct interest to the medical profession;

THEREFORE BE IT RESOLVED, That the House of Delegates request the Council of the Ohio State Medical Association to consider the possibility and advisability of establishing a speakers' bureau to be operated by the State Association for the foregoing purposes, and,

BE IT FURTHER RESOLVED, If, upon investiga-

tion, the organization of a speakers' bureau is found feasible and practicable, the Council take the necessary steps to establish it and appropriate funds for its operation under rules and regulations promulgated by the Council.

On *motion* by Dr. Bowman, seconded by Dr. Lukens and *carried*, the reference committee's report on Resolution D was *adopted*.

Resolution E

Resolution E, introduced by John A. Fraser, East Liverpool, is recommended for adoption without change, as follows:

WHEREAS, Plans are being made by the State Department of Health to extend and improve maternal and child health services and other public health services in Ohio in accordance with the provisions of the Federal Social Security Act, and,

WHEREAS, Representation from the Ohio State Medical Association on an official advisory council to assist in the administration of the public health activities of the Social Security Program in Ohio has been requested by the State Director of Health,

BE IT RESOLVED, That this Association expresses appreciation for this invitation to assist and advise in the administration of these activities, and,

BE IT RESOLVED, That those charged with administration of the public health activities of the Social Security Program in Ohio respectfully be requested to frequently confer with officials of the Ohio State Medical Association on matters of policy and procedure to avoid, if possible, misunderstandings and conflicts, and with officials of component county medical societies on local activities.

BE IT RESOLVED, That the physicians of Ohio individually and collectively be urged to assist and cooperate in the furtherance of this program providing its provisions conform to the fundamental policies approved and adopted by the House of Delegates of the Ohio State Medical Association.

On *motion* by Dr. Bowman, seconded by Dr. Fraser and *carried*, the reference committee's report on Resolution E was *adopted*.

Resolution F

Resolution F, introduced by J. M. Firmin, Findlay, is, in the opinion of this committee, timely and constructive and is, therefore, recommended for adoption as follows:

WHEREAS, It has been noted with disappointment that some of the graduates of medical schools and colleges in recent years apparently are unfamiliar with the objectives and activities of organized medicine and lack a clear understanding of the benefits to be derived through membership in local, state and national medical societies; and,

BE IT RESOLVED, By the House of Delegates of the Ohio State Medical Association, October 2-4, 1935, that the administrative officials of all accredited American medical colleges be respectfully requested to provide instruction for senior students on the activities, services, and benefits of organized medicine.

BE IT RESOLVED, That a copy of this resolution be transmitted to the dean of each of the accredited medical colleges of America, the Council on Medical Education and Hospitals and the Board of Trustees of the American Medical Association, and the secretary of each constituent state medical society.

On *motion* by Dr. Bowman, seconded by Dr. Tuckerman and *carried*, the reference committee's report on Resolution F was *adopted*.

Resolution G

Resolution G, introduced by B. J. Hein, Toledo, deals with a question of great importance to the medical profession generally, has the unanimous approval of the Council of the State Medical Association and therefore is recommended for adoption as follows:

BE IT RESOLVED, By the House of Delegates of the Ohio State Medical Association, on behalf of the medical profession of Ohio, that:

The State Industrial Commission respectfully be requested to give its immediate consideration to rescinding the 20 per cent reduction of medical and surgical fees of physicians for services to beneficiaries of the Workmen's Compensation Law.

The Ohio State Medical Association re-affirms its opposition to any changes in the Ohio Workmen's Compensation System which would modify the fundamental purposes of the compensation law; be detrimental to efficient administration procedure; or mitigate against the best interests of disabled workers.

This Association offers its active assistance in efforts to secure from the General Assembly adequate appropriations for operation of the State Industrial Commission.

Organized medicine reiterates its appreciation of the cooperative attitude displayed in the past by the State Industrial Commission; expresses confidence in the integrity and ability of the Commission to administer the compensation law for the best interests of all concerned; and pledges its active support to the Commission in improving administration of the Workmen's Compensation Law.

On *motion* by Dr. Bowman, seconded by Dr. Burley and *carried*, that part of the reference committee's report dealing with Resolution G was *adopted*.

Resolution H

Resolution H, introduced by H. V. Dutrow, Dayton, seeks to empower the President of the State Medical Association to appoint a permanent committee to be known as "The Committee on Prevention and Amelioration of Deafness". Your reference committee has given serious thought to this resolution. It agrees with the sentiment expressed in the preamble, namely, that the medical profession should take an active interest in educational activities designed to aid in the prevention and amelioration of deafness.

However, we are of the opinion that it is unnecessary to establish a special committee for this specific purpose, and, therefore, recommend that Resolution H not be adopted, but that the House of Delegates in lieu thereof recommend to the Committee on Preventive Medicine and Periodic Health Examinations of the Ohio State Medical

Association that it make a study during the ensuing year of the subject presented in Resolution H, consult with those particularly interested in this question; and submit to the Council of the State Medical Association recommendations as to how medical organization may assist in promoting preventive measures relating to deafness.

On *motion* by Dr. Bowman, seconded by Dr. Dutrow and *carried*, that portion of the reference committee's report dealing with Resolution H was *adopted*.

On *motion* by Dr. Bowman, seconded by Dr. DeWitt and *carried*, the reference committee's report as a whole was *adopted*.

INSTALLATION OF NEW PRESIDENT

Dr. Caldwell expressed appreciation to the House of Delegates for its faithful service at this Annual Meeting, and to all officers, Councilors, committees and members who had given him loyal support and cooperation during the past year. He then introduced Dr. Hendershott, the President-elect, and installed him as President for the coming year, by presenting to him the official gavel. Dr. Hendershott pledged himself to render devoted service to carry on in an efficient manner activities now in operation or planned to extend the usefulness and benefits of medical organization to the individual members.

APPOINTMENT AND CONFIRMATION OF STANDING COMMITTEES

As his first official act, Dr. Hendershott announced the appointment of one member each on the standing committees for a term of three years, as follows:

Public Policy:

C. W. Stone, Cleveland.

Medical Defense:

F. P. Anzinger, Springfield.

Medical Education and Hospitals:

Wm. H. Bunn, Youngstown.

Medical Economics:

L. Howard Schriver, Cincinnati.

On *motion* by Dr. Cummer, seconded by Dr. Hogue and *carried*, the House of Delegates concurred in the foregoing appointments. President Hendershott then announced the complete personnel of standing committees, including hold-over members and the chairman designation, as follows:

Committee on Public Policy:

J. H. J. Upham (1937), Columbus, chairman; John B. Alcorn (1936), Columbus; C. W. Stone (1938), Cleveland; R. R. Hendershott (Ex-Officio), Tiffin; E. M. Huston (Ex-Officio), Dayton.

Committee on Medical Defense:

J. E. Tuckerman (1937), Cleveland, chairman; W. H. Snyder (1936), Toledo; F. P. Anzinger (1938), Springfield.

Committee on Medical Education and Hospitals:

Ben R. McClellan (1937), Xenia, chairman; John F. Wright (1936), Toledo; Wm. H. Bunn (1938), Youngstown.

Committee on Medical Economics:

L. L. Bigelow (1937), Columbus, chairman; J. Craig Bowman (1936), Upper Sandusky; L. Howard Schriver (1938), Cincinnati.

APPRECIATION EXPRESSED

On *motion* by Dr. Alcorn, seconded by several members of the House of Delegates and *carried*, the House of Delegates, on behalf of the Ohio State Medical Association, expressed appreciation to the Cincinnati Academy of Medicine, to its local committees, to the Cincinnati Chamber of Commerce, to the Netherland Plaza, and all persons and groups which had a part in arranging for the 1935 Annual Meeting, for the hospitality extended to those in attendance and for the efficient handling of all details which helped to make the 1935 Annual Meeting one of the best in the history of the State Association. Also incorporated in Dr. Alcorn's motion was a special acknowledgment of the splendid work of the Program Committee headed by Parke G. Smith and composed, in addition, of Dr. Hendershott and Dr. Cummer; as well as of the various Section Officers who gave them loyal cooperation in arranging what was considered by many the best scientific program ever presented by the Association.

The House of Delegates then adjourned to meet in Cleveland in 1936 on dates to be selected by the Council.

Attest: CHARLES S. NELSON,
Executive Secretary.

House of Delegates Roll Call, 89th Annual Meeting

County	Delegate	First Session	Second Session
Adams	Ray Vaughen	Present	
"	S. J. Ellison		present
Allen	C. L. Steer		
Ashland	C. J. Powell		
Ashtabula	R. B. Wynkoop	present	present
Athens	C. S. McDougall	present	
"	T. A. Copeland		present
Auglaize	Guy E. Noble		
Belmont	W. L. Davis	present	present
Brown			
Butler	M. O. Cook		
Champaign	D. C. Houser	present	present
Clark	D. W. Hogue	present	present
Clermont	Carl Minning	present	present
Clinton	Robert Conard	present	present
Columbiana	John A. Fraser	present	present
Coshocton	Floyd Craig		
Crawford	D. G. Arnold		
Cuyahoga	Arthur Stotter	present	
"	O. A. Weber	present	
"	Russell L. Haden	present	present
"	F. C. Oldenburg	present	present
"	E. E. Beard	present	
"	H. C. King	present	present
"	C. G. LaRocco	present	present
"	L. M. Starin	present	present
"	J. E. Tuckerman	present	present
"	H. D. Piercy	present	present

County	Delegate	First Session	Second Session
"	Harold Feil	———	present
"	G. F. Sykes	———	present
"	C. W. Stone	———	present
Darke	C. I. Stephen	present	present
Defiance	D. J. Slosser	present	present
Delaware	D. S. Cowles	———	———
Erie	A. R. Grierson	present	present
Fairfield	Ralph Smith	present	———
Fayette	J. F. Wilson	present	———
Franklin	John M. Thomas	present	present
"	J. B. Alcorn	present	present
"	E. J. Emerick	present	present
"	I. B. Harris	present	present
"	H. M. Platter	present	———
"	J. H. J. Upham	———	present
Fulton	E. A. Murbach	present	present
Gallia	Mary L. Austin	———	present
Geauga	Walter C. Cory	———	———
Greene	H. C. Messenger	present	present
Guernsey	G. F. Swan	present	present
Hamilton	Henry B. Freiberg	present	present
"	Chas. E. Kiely	present	present
"	L. H. Schriver	present	present
"	Louis Feid, Jr.	present	present
"	Otto Seibert	present	present
"	E. O. Swartz	present	present
"	Thos. A. Ratliff	present	present
Hancock	J. M. Firmin	present	present
Hardin	Don R. Printz	———	———
Harrison	Theodore Berg	———	———
Henry	Thomas Quinn	———	———
Highland	H. W. Chaney	present	present
Hocking	C. F. Shonk	present	present
Holmes	———	———	———
Huron	O. J. Nicholson	———	———
Jackson	A. G. Ray	present	present
Jefferson	S. A. Harris	———	———
Knox	F. C. Anderson	present	present
Lake	V. N. Marsh	present	———
Lawrence	George G. Hunter	present	present
Licking	E. A. Moore	———	———
Logan	C. K. Startzman	———	———
Lorain	S. V. Burley	present	present
Lucas	J. F. Wright	present	present
"	C. W. Waggoner	present	present
"	Chas. Lukens	present	present
Madison	G. C. Scheetz	———	———
Mahoning	Sidney McCurdy	present	present
"	C. B. Norris	present	present
Marion	Carl W. Sawyer	———	present
Medina	R. L. Mansell	———	present
Meigs	R. E. Boice	———	———
Mercer	Ralph Beare	———	———
Miami	Foster Kiser	———	———
"	G. A. Woodhouse	———	present
Monroe	———	———	———
Morgan	Galen Rex	———	———
"	C. E. Northrup	———	present
Montgomery	A. W. Carley	present	present
"	H. V. Dutrow	present	present
"	A. O. Peters	present	present
Morrow	F. M. Hartsook	———	present
Muskingum	M. A. Loebell	present	present
Noble	———	———	———
Ottawa	E. D. Schuiteman	———	———
Paulding	L. R. Fast	present	present
Perry	James Miller	———	———
Pickaway	D. V. Courtright	present	———
Pike	R. M. Andre	———	———
Portage	A. M. Landsborough	present	———
Preble	C. J. Brian	present	present
Putnam	A. L. Fipp	———	———
Richland	S. C. Schiller	———	———
Ross	A. E. Merkle	———	———
Sandusky	C. R. Pontius	———	———
Scioto	G. R. Micklethwaite	present	———
Seneca	E. H. Porter	present	present
Shelby	R. E. Paul	———	———
Stark	J. P. DeWitt	present	present
"	A. R. Basinger	present	present
Summit	F. C. Potter	present	present
"	C. R. Steinke	present	present
"	D. B. Lowe	present	present
Trumbull	R. D. Herlinger	———	present
Tuscarawas	W. W. H. Curtiss	———	present
Union	J. D. Boylan	present	present
Van Wert	C. A. Morgan	present	———
Vinton	A. A. Boal	———	———
Warren	S. S. Stahl	present	———
Washington	W. W. Sauer	———	———
Wayne	R. C. Paul	present	present
Williams	H. W. Wertz	present	present
Wood	F. V. Boyle	present	———
Wyandot	J. Craig Bowman	———	present
OFFICERS			
President	John A. Caldwell	present	present
President-Elect	R. R. Hendershott	present	present
Ex-President	C. L. Cummer	present	present
Treasurer	James A. Beer	present	present
COUNCILORS			
First District	Parke G. Smith	present	present
Second District	E. M. Huston	present	present
Third District	O. P. Klotz	present	present
Fourth District	B. J. Hein	present	———
Fifth District	A. A. Jenkins	present	present
Sixth District	H. S. Davidson	present	present
Seventh District	C. W. Kirkland	present	present
Eighth District	E. R. Brush	present	present
Ninth District	I. P. Seiler	present	present
Tenth District	S. J. Goodman	———	———

MEMBERS REGISTERED AT CINCINNATI MEETING TOTAL 973; FIGURES FOR PAST YEARS AND BY COUNTIES SUMMARIZED

THE large attendance at the 89th Annual Meeting in Cincinnati—a total figure which surpassed expectations—indicated a renewed interest on the part of the medical profession of Ohio in the activities and functions of the Ohio State Medical Association and demonstrated that the benefits to be derived from effective and efficient organization work and the educational opportunities offered by the programs of the State Association are appreciated by alert physicians.

The total registration at Cincinnati, including members of the State Association, out-of-state physicians, guests and exhibitors, was 1271.

Members who registered numbered 973.

The registration of guests, including internes, medical students, nurses and women visitors was 197; of out-of-state physicians, 17; and of exhibitors, 84.

The following tabulations show the registration figures for the past succeeding 17 Annual Meetings of the State Association and the number of members registered from each county at the 1935 meeting, compared to the number of members in the county. Nine counties were not represented at the Cincinnati meeting—at least no member from them registered.

Annual Meeting Registration For 1919-1935 Inclusive

Year	Place	Members	Out-of-State Physicians	Guests	Exhibitors	Total
1919	Columbus	1173	10	264	92	1529
1920	Toledo	810	17	105	80	1062
1921	Columbus	1275	28	204	96	1503
1922	Cincinnati	1066	21	184	70	1341
1923	Dayton	1117	19	202	76	1414
1924	Cleveland	1301	13	180	109	1603
1925	Columbus	1204	17	361	107	1689
1926	Toledo	903	19	120	83	1125
1927	Columbus	1320	17	286	82	1705

Year	Place	Members	Out-of-State Physicians	Guests	Exhibitors	Total
1928	Cincinnati	916	27	92	80	1116
1929	Cleveland	1231	15	249	124	1619
1930	Columbus	1241	13	435	86	1775
1931	Toledo	826	13	198	50	1087
1932	Dayton	978	2	201	45	1226
1933	Akron	858	6	160	25	1049
1934	Columbus	1069	9	410	51	1539
1935	Cincinnati	973	17	197	84	1271

Registration, 1935 Annual Meeting by Counties and Membership Data

County	Membership on 10-1-35	No. of Members Registered at 1935 Annual Meeting
Adams	16	6
Allen	69	11
Ashland	21	1
Ashtabula	39	1
Athens	38	6
Auglaize	30	5
Belmont	55	5
Brown	7	3
Butler	77	31
Champaign	17	6
Clark	68	16
Clermont	20	8
Clinton	27	11
Columbiana	52	2
Coshocton	23	---
Crawford	29	1
Cuyahoga	949	72
Darke	32	7
Defiance	14	3
Delaware	23	2
Erie	36	3
Fairfield	36	4
Fayette	15	5
Franklin	402	79
Fulton	18	1
Gallia	23	4
Geauga	10	---
Greene	37	11
Guernsey	32	2
Hamilton	638	348
Hancock	43	6
Hardin	24	1
Harrison	11	1
Henry	13	1
Highland	22	9
Hocking	16	1
Holmes	8	---
Huron	18	1
Jackson	13	2
Jefferson	52	---
Knox	24	3
Lake	28	1
Lawrence	23	3
Licking	48	4
Logan	26	3
Lorain	101	6
Lucas	228	26
Madison	14	2
Mahoning	194	8
Marion	40	4
Medina	22	3
Meigs	12	1
Mercer	19	1
Miami	48	19
Monroe	7	---
Montgomery	284	73
Morgan	11	1
Morrow	9	1
Muskingum	54	6
Noble	1	---
Ottawa	16	1
Paulding	11	2
Perry	19	1
Pickaway	12	3
Pike	8	1
Portage	27	2
Preble	18	7
Putnam	26	2
Richland	54	1
Ross	32	5
Sandusky	34	---
Scioto	68	18
Seneca	33	7
Shelby	20	7
Stark	180	21
Summit	274	24
Trumbull	44	3
Tuscarawas	49	6
Union	16	1
Van Wert	20	3
Vinton	6	---
Warren	21	8
Washington	39	---
Wayne	41	4
Williams	15	1
Wood	36	3
Wyandot	9	1
Total Membership	5394	973

Names of Members Registered

The list of members registered, by counties, follows:

Adams—S. J. Ellison, R. B. Ellison, L. H. Leonard, Hazel Sproull, O. T. Sproull, Ray Vaughen. *Allen*—I. D. Baxter, R. B. Krouse, Chas. H. Leech, Walter A. Noble, W. H. Parent, W. V. Parent, O. S. Robuck, John J. Sutter, J. R. Terwilliger, J. R. Tillotson, Harold C. Weisenbarger. *Ashland*—Elmer L. Jackson.

Ashtabula—R. B. Wynkoop. *Athens*—A. K. Buell, T. A. Copeland, Chas. S. McDougall, J. Merwin, C. S. Small, John R. Sprague. *Auglaize*—Chas. C. Berlin, E. F. Heffner, R. C. Hunter, Guy E. Noble, Harry S. Noble. *Belmont*—E. V. Arbaugh, Jr., W. L. Davis, C. W. Kirkland, C. B. Messerly, J. F. Sutton.

Brown—R. B. Hannah, J. W. Kautz, Geo. P. Tyler. *Butler*—C. T. Atkinson, Hugh J. Baker, E. O. Bauer, D. M. Blizzard, Malcolm Bronson, Fred Brosius, Merle Flenner, Mildred White Gardiner, David F. Gerber, William H. Henry, G. A. Hermann, Ross A. Hill, Vera C. Iber, G. D. Lummis, Mark Millikin, H. A. Moore, E. McCall Morris, T. A. Munus, Walter A. Reese, W. T. Shipe, Louis H. Skimming, Anderson L. Smedley, H. H. Smith, Mildred L. Snyder, C. A. Spitler, W. T. Stewart, E. T. Storer, J. C. Stratton, F. E. Ulrey, Claude L. Weston, Willis A. Whitman.

Champaign—E. D. Buhrer, D. C. Houser, J. W. Norman, W. H. Sharp, V. G. Wolfe, W. A. Yinger. *Clark*—F. P. Anzinger, I. H. Boesel, A. W. Detrick, J. C. Easton, C. W. Evans, S. E. Flook, E. R. Hargett, F. A. Hartley, Delos W. Hogue, Clement L. Jones, G. M. Lane, J. A. Link, W. H. Miller, John Srail, Bennetta D. Titlow, Will Ultes. *Clermont*—Jas. K. Ashburn, C. F. Barber, J. M. Coleman, O. C. Davison, W. H. Gaskins, Carl Minning, Pearl Zeek Minning, Allan B. Rapp. *Clinton*—Robert Conard, F. E. Craig, Glenn K. Dennis, Kelley Hale, V. E. Hutchens, C. E. Kinzel, E. D. Peele, A. C. Roberts, Elizabeth Shrieves, C. A. Tribbett, Wm. L. Wead. *Columbiana*—John A. Fraser, E. C. Louthan. *Crawford*—C. A. Lingenfelter.

Cleveland and Cuyahoga—John P. Anderson, E. E. Beard, Claude S. Beck, M. A. Blankenhorn, J. L. Bubis, Milton B. Cohen, Clyde L. Cummer, Leon H. Dembo, Fred W. Dixon, Marion Douglass, I. H. Einsel, A. Carlton Ernstene, Warren C. Fargo, Robert L. Faulkner, Harold Feil, R. W. Finley, J. Edgar Fisher, G. K. Folger, S. T. Forsythe, S. O. Freedlander, Wm. J. Gardner, Marion N. Gibbons.

Otto L. Goehle, C. Lee Graber, Russell L. Haden, Clarence T. Hemmings, Fannie C. Hutchins, Theron S. Jackson, A. A. Jenkins, Henry J. John, Thomas E. Jones, Louis J. Karnosh, E. P.

Kennedy, Hubert C. King, Sydney Klein, W. B. Landesman, G. L. Lambright, C. G. LaRocco, F. A. LeFevre, William E. Lower, Frank W. Milward, Horace E. Mitchell, S. H. Monson, B. H. Nichols, Fred C. Oldenburg, H. D. Piercy, Robert A. Reading, Rudolph A. Reich, Herbert S. Reichle, James L. Reycraft, H. D. Roads, H. L. Rockwood, V. C. Rowland.

J. A. Rudolph, A. D. Ruedemann, Scott C. Runnels, R. W. Scott, A. O. Sibila, A. J. Skeel, L. M. Starin, Charles W. Stone, Willard C. Stoner, Arthur L. Stotter, G. F. Sykes, B. H. Taylor, John A. Toomey, J. E. Tuckerman, Chas. T. Way, O. A. Weber, Beulah Wells, S. Yamshon.

Darke—W. D. Bishop, W. T. Fitzgerald, W. C. Gutermuth, E. G. Husted, Paul G. Lenhert, B. F. Metcalfe, C. I. Stephen. *Defiance*—John U. Fauster, Jr., Paul B. Newcomb, B. J. Slosser. *Delaware*—W. E. Borden, Frank G. Grace. *Erie*—A. R. Grierson, V. A. Killoran, Charles J. Reichenbach.

Fairfield—A. M. Kelley, H. R. Plum, Ralph H. Smith, K. W. Taylor. *Fayette*—L. L. Brock, N. M. Reiff, A. S. Stemler, James F. Wilson, Orlyn Wiseman.

Columbus and Franklin County—N. A. Albanese, John B. Alcorn, Hugh G. Beatty, James A. Beer, Leslie L. Bigelow, Emerson M. Blake, J. E. Briggs, E. H. Chapin, Ivor G. Clark, George Curtis, Wm. C. Davis, Charles A. Doan, Verne A. Dodd, John Dudley Dunham, A. H. Dunn, S. D. Edelman, E. J. Emerick, Earl W. Evans, J. P. Farson, R. S. Fidler, T. R. Fletcher, Jonathan Forman, Clarence Fry, H. D. Giles, S. J. Goodman, F. W. Gosnell, George T. Harding.

Frank W. Harrah, Edward W. Harris, Harold K. Harris, I. B. Harris, E. R. Hayhurst, E. Herbst, Carrole E. Herron, E. G. Horton, C. D. Hoy, Maurice M. Kane, G. W. Keil, R. A. Kidd, Sr., R. A. Kidd, Jr., C. C. Kirk, Herman W. Koerper, F. F. Lawrence, H. E. LeFever, W. E. Lloyd, Louis Mark, E. F. McCampbell, A. B. McConagha, M. E. Millhon, John H. Mitchell, W. E. Obetz.

E. F. Peinert, H. M. Platter, Joseph Price, W. H. Pritchard, W. L. Pritchard, R. A. Ramsey, John Rauschkolb, Frank Riebel, Andrews Rogers, Paul S. Ross, C. E. Sharp, C. C. Sherburne, Geo. P. Sims, S. S. Stahl, Edwin J. Stedem, Wells Teachnor, Sr., John M. Thomas, A. A. Thrall, Chas. E. Turner, A. L. Van Horn, Finley Van Orsdall, Thos. A. Vogel, J. H. J. Upham, F. C. Wagenhals, James H. Warren, John W. Wilce, Bruce K. Wiseman.

Fulton—E. A. Murbach. *Gallia*—Mary L. Austin, S. L. Bossard, Charles E. Holzer, G. A. Mack. *Greene*—Paul D. Espey, T. F. Humphrey, Ben R. McClellan, Reyburn McClellan, C. G. McPherson, A. C. Messenger, H. C. Messenger, T. F. Myler, Harold E. Ray, A. D. Ritenour, David Taylor. *Guernsey*—A. G. Ringer, George F. Swan.

Cincinnati and Hamilton County—Glenn Adams, M. M. Adams, E. Asbury, Mary Knight Asbury, C. S. Ashfield, Richard S. Austin, E. A. Baber, J. F. Bateman, Charles W. Beaman, Joseph J. Bell, J. E. Benjamin, George Benzing, Jr., Oscar Berghausen, Henry W. Bettmann, A. G. Beyer, Joseph B. Biederman, Joseph Bolin, Grace M. Boswell, Mark E. Bowles, B. E. Boyer, F. J. Boyd, D. J. Bradley, M. B. Brady, E. B. Brandes, L. E. Brinker, W. L. Brodberger, Albert L. Brown, Samuel Brown, Susan W. Brown, W. E. Brown, Wm. Bruggemann, Ben L. Bryant, Leslie M. Buckner, John A. Caldwell, Elizabeth Campbell, A. G. Carmel, Ralph G. Carothers, Robert Carothers, A. H. Carr, B. N. Carter, Gerald H. Castle, William R. Chambers, A. T. Childers, Wm. C. Clarke, Geo. E. Clarke, James T. Clear, Robert B. Cofield, Sander Cohen, H. F. Conwell, Louis E. Cook, Merlin L. Cooper, Frank W. Coppock, Jr., C. G. Crisler, Nora Crotty, Frank B. Cross, R. L. Crudgington, E. A. Curry.

John C. Danahy, S. Bertha Dauch, Daniel J. Davies, C. Ross Deeds, D. M. Denman, William Doughty, Harold Downing, H. Drachenberg, Ralph R. DuCasse, C. E. Eha, Charles K. Ervin, C. J. Fairo, Louis Feid, Jr., Lloyd K. Felton, Willard B. Fessenden, Frank F. Ferris, Nancy E. Finney, Martin H. Fischer, John A. Fisher, Nathan Flax, A. W. Foertmeyer, E. I. Fogel, Starr Ford, Jr., Lee Foshay, N. I. Fraid, Albert H. Freiberg, Henry B. Freiberg, Edward Friedman, Leo S. Friedman, Alfred Freelander, Mabel E. Gardner, Otto P. Geier, Elizabeth Gillespie, Thad R. Gillespie, William P. Gillespie, A. E. Gillette, Alfred M. Glazer, Thomas J. Glenn, Leon Goldberg, S. J. Goldberg, Leon Goldman, Douglas Goldman, Harry Goldstein, Ralph Wm. Good, Henry M. Goodyear, Charles Goosmann, Wm. J. Graf, J. Victor Greenebaum, Aaron I. Grollman, Henry Gruener, George M. Guest.

Albert L. Haas, W. D. Haines, Paul Hamilton, D. C. Handley, C. L. Hans, Kenneth B. Hanson, F. K. Harder, Charles E. Hauser, Frank C. Heffner, George Heidelman, Jos. D. Heiman, Charles D. Heisel, Anthony B. Hendricks, Hugh Hengstenberg, Louis G. Herrmann, Wm. C. Herman, P. W. Hess, Mortimer Herzberg, D. W. Heusinkveld, Louis G. Heyn, H. G. Higginbotham, Carl Hiller, J. Isfred Hofbauer, Charles A. Hofling, George H. Holt, Oliver P. Holt, Chas. E. Howard, Benjamin Hoyer, Morris Hyman, Samuel Iglauer, M. J. Inskeep, J. J. Jennie, Ivan S. C. Johnson, D. A. Johnston, Lloyd B. Johnston, Robert Lee Johnston, F. A. Kautz, Leonard Kawasaka, E. M. Keefe, Robert A. Kehoe, Lee Keidel, H. C. Kendall, Chas. E. Kiely, D. J. Kindel, E. A. Kindel, Allen T. King, Arthur G. King, Clarence King, Edward King, C. R. Kitsmiller, V. R. Kitsmiller, K. V. Kitzmiller, E. A. Klein, W. W. Klement, Geo. H. Knapp, Arthur L. Knight, C. W. Koehler, Wm. H. Koehler, J. C. Kunz, Rudolph F. Kurz.

M. C. Labermeirer, Harry Landt, C. A. Langdale, Sidney Lange, Harry Lapirow, Inez Lapsley, H. Jerry Lavender, J. Arthur Leary, J. W. Leichliter, Harry O. Lepsky, A. A. Levin, Edwin L. Libbert, A. J. Light, Joseph Lindner, Louis P. Linss, Gerson Lowenthal, George Lyford, D. J. Lyle, Robert A. Lyon, Hugh W. MacMillan, J. W. McCammon, J. E. McCarthy, Geo. W. McClure, Charles J. McDevitt, Lester McDevitt, Johnson McGuire, R. D. Maddox, Leo R. Majoewsky, John J. Maloney, Morris Mark, Richard R. Marnell, Anthony Matuska, Sidney N. Mendelsohn, Paul Merrell, William M. Millar, John D. Miller, J. S. Mills, A. Graeme Mitchell, Wm. Mithoefer, Gilbert Mombach, Joseph Nakayama, Chas. A. Neal, A. W. Nelson, Harry G. Nelson, B. Newberger, E. H. Niesen, Charles S. Noonan, Emerson A. North, Vera Norton.

Carl J. Ochs, J. C. Oliver, Symmes F. Oliver, Dale P. Osborn, F. M. Oxley, Evalyn M. Partymiller, George F. Patterson, J. N. Patterson, C. T. Pearce, C. T. Perin, Jr., J. Edw. Pirrung, Charles L. Pfeiffer, Walter B. Phillips, James M. Pierce, S. H. Portnoy, W. O. Ramey, J. L. Ransohoff, Norman A. Ratliff, Helena T. Ratterman, Louise W. Rauh, Horace W. Reid, Mont R. Reid, Harold G. Reineke, Andrew C. Renz, Dewey H. Reps, H. H. Rinehart, C. R. Rittershofer, D. C.

Rivers, William Roach, V. Bradley Roberts, G. R. Roessly, Wm. H. Rohdenburg, Clyde S. Roof, A. C. Ross, A. Rothenberg, Robert C. Rothenberg, J. W. Rowe, Barnet R. Sakler, N. L. Saltzman, Moses Salzer, Leon Schiff, Elmer W. Schlemmer, Elmer A. Schlueter, Wm. C. Schmidter, E. H. Schoenling, Howard Schriver, J. H. Schroeder, A. L. Schwartz, Bernard A. Schwartz, Otto Seibert, Frank Seinsheimer, Theodore K. Selkirk, Samuel Seltz, Reed A. Shank, E. C. Shinkle, Charles M. Siegel, C. R. Sikes, E. Silberstein.

John H. Skavlem, Robert E. Slemmer, N. F. Slomer, Hiram H. Slutz, Parke G. Smith, S. H. Smith, Louis Sommer, Dora F. Sonnenday, J. C. Staats, Henry Stanbery, J. R. Stark, C. Roy Steingrube, Edgar C. Steinharter, Thomas M. Stewart, H. L. Stitt, Walter H. Stix, Clifford J. Straehley, Erwin Straehley, Sr., Erwin Straehley, Jr., E. M. Strasser, Cecil Striker, M. Strikman, A. E. W. Stueve, Paul W. Sutton, E. O. Swartz, Emil R. Swepston, Frank U. Swing, H. F. Tangeman, Bernyce Tavel, L. G. Tedesche, Wm. S. Terwilleger, Wm. A. Teveluve, F. C. Theiss, Clyde S. Thomas, Edward R. Thomas, Geo. B. Topmoeller, Wm. J. Topmoeller, David A. Tucker, Jr., J. L. Tuechter, C. W. Tunison, Derrick Vail, Harris H. Vail, J. H. Ventress, A. R. Vonderahe, Edward A. Wagner, Millard Wallenstein, David E. Weaver, Joseph L. Weil, Josef D. Weintraub, H. B. Weiss, Arthur W. Wendel, Theodore H. Wenning, Wm. Wertheim, S. W. Whitehouse, Charlotte Wiedemer, A. M. Wigser, Abbott Y. Wilcox, Jr., H. Meade Wiley, Foster M. Williams, John H. Wilms, Cloyce Wilson, Carl A. Wilzbach, John J. Winn, Sydney Wolfgang, George D. Woodward, H. L. Woodward.

C. E. Young, Jerome Zeigler, Mendel Zeligs, Samuel Zielonka, M. M. Zinninger, Rudolph M. Zodikoff, Albert R. Zoss, Karl G. Zwick.

Hancock—J. M. Firmin, John V. Hartman, O. P. Klotz, E. E. Rakestraw, A. J. Reycraft, Frank M. Wiseley. *Hardin*—R. C. McNeill. *Harrison*—E. L. Miller. *Henry*—C. M. Harrison. *Highland*—J. C. Bohl, H. W. Chaney, Chas. C. Cropper, Clifford G. Foar, J. C. Larkin, H. H. Lowe, T. W. Roberds, Morton A. Roth, K. R. Teachnor. *Hocking*—Chas. F. Shonk. *Huron*—O. J. Nicholson.

Jackson—A. G. Ray, O. McLaughlin. *Knox*—F. C. Anderson, C. L. Harmer, James F. Lee. *Lake*—V. N. Marsh. *Lawrence*—Chester A. Casey, E. E. Ellsworth, George G. Hunter. *Licking*—H. B. Anderson, George A. Gressle, J. B. Johnson, Jr., Dale E. Roth. *Logan*—Omas C. Amstutz, C. L. Barrett, F. B. Kaylor.

Lorain—S. V. Burley, Benjamin Carlson, Philip Katz, Gertrude Moulton, Geo. Mynchenberg, E. J. Novotny. *Lucas*—Carl H. Bayha, Walter Brand, E. W. Campbell, Fred M. Douglass, Fred L. Eyestone, Karl D. Figley, H. M. Foster, J. Gardiner, Norris W. Gillette, Barney J. Hein, Paul M. Holmes, I. H. Kass, Rollin Kuebbeler, B. E. Leatherman, L. A. Levison, Chas. Lukens, H. B. Meader, Edward J. McCormick, Louis A. Miller, Nelson Morris, Thos. L. Ramsey, A. H. Schade, R. A. Tank, C. W. Waggoner, John F. Wright, Theo. Zbinden.

Madison—Paul Hildebrant, J. M. Morse. *Mahoning*—W. H. Bunn, James L. Fisher, Sidney McCurdy, Claude B. Norris, F. F. Piercy, Samuel H. Sedwitz, Wm. M. Skipp, O. J. Walker. *Marion*—S. W. Mattox, H. K. Mouser, Carl W. Sawyer, Bernard H. Taylor. *Medina*—E. L. Crum, Thomas W. Mahoney, R. L. Mansell.

Meigs—M. S. Daniels. *Mercer*—L. M. Otis. *Miami*—Charles Baker, John F. Beachler, M. M. Brubaker, Don F. Deeter, Russell Gardner, C. E. Hetherington, E. R. Hiatt, John F. Hill, Berton M. Hogle, Emory R. Irvin, Foster D. Kiser, L. N. Lindenberger, E. G. Puterbaugh, John T. Quirk, R. D. Spencer, W. W. Trostel, G. A. Woodhouse, E. A. Yates, Ralph D. Yates.

Montgomery—W. R. Althoff, E. R. Arn, Roy D. Arn, Sterling H. Ashmun, Robert C. Austin, Roy S. Binkley, E. E. Bohlender, R. R. Bond, A. T. Bowers, A. B. Brower, Herbert L. Brumbaugh, C. E. Burgett, A. W. Carley, Homer D. Cassel, W. C. Clark, Abe Cline, Marion W. Coleman, D. B. Conklin, A. D. Cook, M. E. Coy, F. W. Cox, Lloyd H. Cox, W. H. Delscamp, C. J. Derby, T. H. Dickinson, E. B. Doan, R. C. Doan, H. V. Dutrow, A. G. Farmer, Gertrude Felker, C. D. Fife.

Curtiss Ginn, Gerald C. Grout, H. C. Hanning, Harry B. Harris, J. Hartman, G. A. Hochwalt, W. R. Hochwalt, J. K. Hoerner, C. B. Horton, R. D. Hostetter, Chas. T. Hunt, E. M. Huston, Harry R. Huston, J. W. Irwin, Harold M. James, L. M. Jones, B. W. D. Keever, P. A. Kemper, P. H. Kilbourne, Jos. S. Koehler, Albert F. Kuhl, C. J. Mardis, A. P. McDonald, J. W. Millette, P. E. Newell, F. C. Payne, A. O. Peters, Lydia L. Poage, M. D. Prugh, Wallace E. Pugh, Thomas P. Sharkey, C. E. Shepard, Walter Simpson, C. D. Slagle, W. L. Slagle, Clement D. Smith, E. W. Smith, J. D. Spaid, R. H. Spitler, W. B. Taggart, H. H. Wagner, W. Burnett Weaver. *Morgan*—C. E. Northrup.

Morrow—F. M. Hartsook. *Muskingum*—Edmund R. Brush, S. P. Carter, Beatrice T. Hagen, M. A. Loebell, Robert S. Martin, C. F. Sisk. *Ottawa*—F. E. Miller. *Paulding*—L. R. Fast, Fred E. Spragens. *Perry*—F. J. Crosbie. *Pickaway*—D. V. Courtright, G. R. Gardner, A. W. Holman. *Pike*—I. P. Seiler. *Portage*—A. M. Landsborough, S. U. Sivon.

Preble—C. J. Brian, J. A. Carter, J. W. Coombs, C. E. McKinley, C. E. Newbold, James I. Nisbet, E. P. Trittschuh. *Putnam*—W. D. Hickey, B. E. Watterson. *Richland*—J. L. Stevens. *Ross*—Geo. W. Cooper, H. M. Crumley, L. T. Franklin, Louis Sentiff, O. P. Tatman.

Scioto—Dow Allard, D. A. Berndt, R. P. Elder, C. L. Ferguson, A. P. Hunt, J. D. Jordan, Milton Levine, J. P. McAfee, T. G. McCormick, Gilbert Micklethwaite, M. P. Moore, John T. Murchie, K. E. Poetker, W. A. Quinn, Harry F. Rapp, Joseph S. Rardin, H. A. Schirrmann, Oral D. Tatje.

Seneca—Albert C. Chamberlain, R. R. Hendershott, R. R. Kerchner, John M. Leahy, P. J. Leahy, R. Machamer, E. H. Porter. *Shelby*—Herman C. Clayton, J. F. Connor, A. B. Gudenkauf, Kenneth Hawver, A. W. Hobby, C. C. Hussey, S. C. Yinger.

Stark—A. R. Basinger, J. R. Beiter, S. B. Berkley, L. A. Buchman, J. P. DeWitt, R. Winter Frankman, C. E. Fraunfelter, V. Z. Garster, H. W. W. Gauchat, Fred G. King, George L. King, Jr., E. J. March, A. R. Olmstead, C. S. Palmer, Chester M. Peters, C. A. Portz, C. J. Schirack, F. S. Van Dyke, J. S. Williams, Geo. F. Zinninger, Pauline Zinninger.

Summit—O. P. Allen, Robert T. Allison, Jr., T. L. Bliss, James G. Blower, John L. Brickwede, O. J. Chaney, S. B. Conger, M. B. Crafts, Harry S. Davidson, A. F. Dorner, A. H. Franks, Burr M. Hathaway, R. F. Jukes, H. G. Long, D. B. Lowe,

R. H. Markwith, J. S. Millard, Carl C. Nohe, F. C. Potter, H. V. Sharp, Jay D. Smith, Fannie R. Stees, Carl R. Steinke, Karl D. Way.

Trumbull—E. Gray Caskey, R. D. Herlinger, E. G. Kyle. *Tuscarawas*—David H. Allen, H. A. Coleman, W. W. H. Curtiss, Clark M. Dougherty, R. J. Foster, J. M. Smith. *Union*—John Dean Boylan. *Van Wert*—S. A. Edwards, C. A. Morgan, J. B. Sampsell. *Warren*—James H. Arnold, Edward Blair, Henry M. Brown, C. Haarlammert, N. A. Hamilton, Leonard Mounts, S. S. Stahl, P. W. Tetrick. *Wayne*—L. A. Adair, R. C. Paul, Alonzo C. Smith, W. B. Turner.

Williams—H. W. Wertz. *Wood*—F. V. Boyle, Paul F. Orr, Dan B. Spitler. *Wyandot*—J. Craig Bowman.

PROCEEDINGS OF THE COUNCIL

Numerous Items of Business Transacted at Sessions Held During the 89th Annual Meeting of the State Association, October 2, 3 and 4, 1935, at Cincinnati

MINUTES

THE Council of the Ohio State Medical Association met at dinner at the Netherland Plaza, Cincinnati, October 1, 1935, the day preceding the opening of the 89th Annual Meeting of the State Association.

Those present were: President Caldwell, President-Elect Hendershott, Ex-President Cummer, Treasurer Beer; Councilors, Drs. Smith, Huston, Klotz, Hein, Jenkins, Davidson, Kirkland, Brush, Seiler and Goodman; Former Presidents Ben R. McClellan, J. S. Rardin, Robert Carothers, L. L. Bigelow, A. H. Freiberg, D. C. Houser and H. M. Platter; Dr. J. E. Tuckerman, chairman, Committee on Medical Defense; Dr. Andrews Rogers, chairman, Publication Committee; Dr. John B. Alcorn, member, Committee on Public Policy; Dr. Edward D. King, president, Cincinnati Academy of Medicine; Executive Secretary Nelson and Assistant Executive Secretary Saville.

Following the dinner the Council convened for a business session.

There being no objections, the minutes of the Council meeting held on July 28, 1935 (pages 694-698, September, 1935, issue of *The Journal*) were *approved* as published.

ANNUAL MEETING ANNOUNCEMENTS

Dr. Smith, chairman of the Program Committee and the Committee on Arrangements, reported plans had been completed for the 89th Annual Meeting to open Wednesday, October 2. Dr. Smith reviewed briefly the high spots of the official program. Dr. King spoke briefly on the plans of the Cincinnati Academy for entertaining the visiting physicians and extended a hearty welcome to the medical profession of Ohio on behalf of the members of the Cincinnati Academy.

REPORT OF JUDICIAL COMMITTEE

Dr. Cummer, chairman of the Judicial Committee, submitted a report relative to the suspension and expulsion of Dr. C. E. Savage, Delphos, by the Academy of Medicine of Lima and Allen County, and Dr. Savage's appeal from such action to the Council of the State Association. Correspondence bearing on the case was read. Dr. Klotz, Councilor of the Third District, made a verbal report on interviews with officers of the Academy of Medicine of Lima and Allen County and Dr. Savage. Dr. Klotz stated that negotiations had been initiated in an effort to bring about an amicable settlement of the case. For this reason, on *motion* by Dr. Huston, seconded by Dr. Davidson and *carried*, the Council deferred action until its next meeting, and upon *motion* by Dr. Klotz, seconded by Dr. Goodman and *carried*, the executive secretary was instructed to write the secretary of the Academy of Medicine of Lima and Allen County and Dr. Savage explaining to them why the Council had deferred action and expressing to them the hope of the Council that an agreement might be reached locally between now and the next regular Council meeting.

A request from the Summit County Medical Society asking approval by the Council of an amendment to the By-Laws of that society adopted May 7, 1935, was read. Upon *motion* by Dr. Huston, seconded by Dr. Davidson and *carried*, the amendment and correspondence were referred to the Judicial Committee with instructions to report at the next Council meeting.

SOCIAL SECURITY ACT

A communication from Dr. Walter H. Hartung, State Director of Health, addressed to the Ohio State Medical Association was read. It requested the Council of the State Medical Association to nominate a representative on a contemplated advisory council to be set up to assist the State Department of Health in administering all public health activities to be carried on in Ohio as a part of the Federal Social Security Act.

Following a lengthy discussion, the Council, upon *motion* by Dr. Seiler, seconded by Dr. Brush and *carried*, expressed appreciation to Dr. Har-

tung for his invitation to the State Medical Association to cooperate with the State Department of Health on this matter, and instructed the President to nominate Dr. J. H. J. Upham, chairman of the Committee on Public Policy, as the official representative of the State Medical Association on the advisory council, with the provision if Dr. Upham is unable to serve that the President use his own discretion in naming an alternate representative.

SERIOUS LEGISLATIVE PROBLEMS

For the information of the Council, questions which had arisen in connection with the special session of the Ohio General Assembly were reviewed and attention was called to the fact that doubtless the Legislature will be in session indefinitely for the purpose of considering proposed legislation dealing with taxation, old age pensions, poor relief, workmen's compensation, finances, etc. The possibility of re-enactment of the retail sales tax with amendments to extend it to professional and non-professional services, was discussed. At this point, Dr. Alcorn, representing the Committee on Public Policy, submitted to the Council a report on the taxation question, in which were outlined statements of policy to guide the medical profession in its contacts with members of the Legislature and definitely expressing opposition to the enactment of unjust and discriminatory taxes on members of the medical profession.

On *motion* by Dr. Huston, seconded by Dr. Jenkins and *carried*, the report was officially adopted by the Council as follows:

Statement of Policy Committee

Before the end of the year, the Ohio General Assembly undoubtedly will be called into special session for the purpose of considering the enactment of new taxes, extending the life of present tax laws and/or broadening the scope of existing revenue-producing acts.

In all probability the medical profession will be called upon to express its views on taxation matters and, perhaps, be compelled to take aggressive action to prevent the levy of unjust and discriminatory taxes on physicians.

For that reason, it is essential that the State Medical Association have a definite policy on this immediate problem to guide the Committee on Public Policy and the legislative committeemen of the component county medical societies, as well as members of the profession generally, in their contacts with members of the General Assembly.

After much deliberation, the Committee on Public Policy offers the following statement for the consideration of the Council and suggests that it be endorsed as the official viewpoint of organized medicine on anticipated taxation issues:

Recent investigations have revealed data indicating little, if any, additional revenue is needed at this time to enable state and local governments to operate efficiently and that substantial savings can be made by the curtailment or elimination of unnecessary or superfluous governmental activities and the adoption of more efficient administrative procedures in many governmental departments.

Assuming these data are accurate, there appears to be no necessity for new forms of taxation.

Numerous suggestions have been made as to possible new sources of revenue. Some of these, we believe, are particularly objectionable to members of the medical profession.

The enactment of any proposal providing for the extension of the Ohio Retail Sales Tax to medical services should be opposed by organized medicine.

If this is done, physicians would have to become tax collectors; secure a vendor's license; and have to keep a rather complicated set of records for inspection by tax officials.

Obviously, many physicians' offices are not equipped to do this. Besides, the average physician is already over-burdened with paper work.

The most serious objection lies in the fact that in effect physicians would have to absorb the tax in many instances.

Theoretically, the physician would purchase the tax coupons and be reimbursed when the patient pays his bill and the tax.

However, the physician in all probablity extends more credit and collects a smaller percentage of his accounts than any other vendor of services or merchandise.

Accounts are carried on the physician's books for months and years. On slow-paying accounts the physician would have considerable money tied up in tax coupons for an indefinte period.

Where bills cannot be collected—and they are numerous these days—the physician would be out the amount paid out by him in purchasing the tax coupons.

If a merchant sells a piece of furniture, for example, on credit and pays the tax in advance for the purchaser, he can retrieve the article and sell it second-hand for enough to reimburse himself for the tax. The physician cannot. He cannot retrieve the services he has rendered. If a patient does not pay his bill, the physician not only loses his fee but also the money he has advanced to purchase tax coupons.

Because of the humanitarian character of his work, the physician cannot refuse services to a patient simply because he refuses to pay the sales tax in advance. The merchant can, if he desires.

The enactment of a tax on gross receipts—in effect an income tax without exemptions, or at the best, meager exemptions, should be opposed.

The hardship such a tax would work on many physicians whose collections at present are hardly sufficient to meet overhead expenses is obvious.

In fact, a proposal of this kind would be even more objectionable than one extending the provisions of the sales tax to medical services for the reason that the sales tax law, theoretically at least, provides the physician with an opportunity to pass on the tax to those receiving his services.

Any attempt to enact professional, occupational or privileged taxes which would be discriminatory with respect to physicians and others engaged in professional pursuits, should be vigorously opposed.

It is recommended that copies of this statement be sent to the officers and legislative committeemen of the component county medical societies to guide them and the members of their societies in their contacts with members of the Legislature.

During the discussion, the importance of constant, vigorous contact on the part of local legislative committeemen with members of the Legislature was emphasized and the Policy Committee and the State Headquarters Office instructed to keep in close touch with all legislative committeemen through correspondence, bulletins, etc.

WORKMEN'S COMPENSATION

Copies of the report of the Sherrill Investigating Commission dealing with workmen's compensation were distributed to those present, and attention was called to the article summarizing the report published in the September, 1935, issue of *The Journal*, pages 704-707.

Dr. Hein, special member of the Committee on Medical Economics, reported that new negotiations with the State Industrial Commission were underway, seeking primarily to have the Commission restore the 20 per cent reduction in medical and surgical fees. Dr. Hein stated that officials of the Commission have promised early consideration of the request made by the Council several months ago for restoration of the 20 per cent reduction, and that the numerous investigations which have been made of the Commission and its various departments had delayed official action by the Commission on this matter.

Dr. Hein read and discussed a resolution which he contemplated submitting to the House of Delegates of the State Medical Association at its first meeting on Wednesday afternoon, October 2. Upon *motion* by Dr. Brush, seconded by Dr. Huston and *carried*, the resolution was *approved* by the Council, which instructed Dr. Hein to submit it for consideration of the members of the House of Delegates. (See proceedings of the House of Delegates in this issue for resolution and its adoption).

GOVERNMENT SURVEY

The attention of the Council was called to the article published in the October, 1935, issue of *The Journal* on the survey and recommendations of the Sherrill Commission regarding the State Department of Health and the State Medical Board. During the general discussion, Dr. Platter, secretary of the State Medical Board, briefly summarized the recommendations of the Sherrill report regarding the activities of the Medical Board.

POOR RELIEF AND OLD AGE PENSIONS

Recent developments in the Ohio poor relief program were reviewed and discussed by the Council. It was pointed out that the Federal Government is gradually withdrawing from the field of direct relief in Ohio and that in the near future all local subdivisions doubtless will be confronted with the responsibility of providing all types of direct relief for persons unable to find employment in private industry or on WPA projects. The Council expressed the hope that officers of county medical societies and medical advisory committees will confer immediately with local governmental officials in an effort to work out a satisfactory medical relief program based on local needs and conditions.

It was pointed out that the WPA program is now in effect in most parts of the state. A bulletin transmitted to the officers of every county medical society by the state WPA director was read, in which the cooperation of the medical societies on the medical phases of the WPA program was requested. Figures obtained from the WPA office in Columbus indicated that a large number of county medical societies had not submitted a list of qualified physicians who would be available to render service to those disabled while employed on WPA projects. The Council expressed the hope that all county medical societies would submit such lists immediately and the suggestion was made that the names of all members of the respective societies be incorporated in the lists submitted.

The report of the Sherrill Investigating Commission on the Division of Aid for the Aged was discussed, especially that portion of the report dealing with medical phases of the old age pension program. Particular attention was devoted to the following recommendation of the Sherrill Commission:

"*The New Law Should Make Some Definite Provision for Medical Care.* 143 or 81 per cent of those cases studied in this survey needed medical care, and only 46 or 31 per cent were receiving such. The amount of the award, even at its maximum does not provide sufficient to cover medical care plus living expenses. The State A.F.A. has made a ruling allowing $1.00 per month to each patient in need of medical care, but this obviously is inadequate as it would not pay for a single visit of a physician. However, if this much additional were allowed in the state appropriation for every recipient and the total amount pooled to *employ* competent medical and hospital service under some comprehensive plan for all recipients of A.F.A. very good medical and hospital care could be provided. It is, therefore, recommended that the proposed new law provide specifically for medical and hospital and nursing care on such a basis, the plan to be worked out in detail by the A.F.A. Division and representatives of the medical profession. The physicians *employed* for this work should be paid enough to secure competent medical service and should be sponsored by the local academies of medicine, or other outstanding medical society in each community."

On *motion* by Dr. Smith, seconded by Dr. Kirkland and *carried*, the Committee on Public Policy was instructed to study the foregoing recommendation, contact old age pension officials and members of the Governor's committee preparing legislation to put the Sherrill recommendations into effect, and report its findings to the Council at its next meeting.

MISELLANEOUS

Attention of the Council was called to the fact

that the State Headquarters Office has assembled packages of material on socialized medicine which are being distributed upon request to teachers in the various colleges and high schools of Ohio where students are planning debates during the ensuing months on the question of state medicine. It was pointed out that numerous packages had already been distributed and that the various county medical societies have been urged to cooperate in seeing that debate students are supplied with authentic literature on this question.

The State Headquarters Office was instructed to cover the 45th Ohio Welfare Conference to be held in Columbus, October 15 to 18, at which questions dealing with health insurance, public health administration, medical poor relief, old age pensions, etc., will be discussed.

Correspondence suggesting copyrighting *The Journal* was discussed by Dr. Rogers, chairman of the Publication Committee. On *motion* by Dr. Hein, seconded by Dr. Jenkins and *carried*, the matter was deferred pending further study.

Dr. Tuckerman, chairman of the Committee on Medical Defense, reviewed recent correspondence dealing with the question of the unauthorized practice of law, and reported that his committee is watching any developments which might have an effect on the medical defense plan of the State Association.

A letter from Lt. Col. W. B. Borden, Fifth Corps Area Surgeon, Fort Hayes, Columbus, stating that physicians on active service at CCC camps are not expected to engage in private practice except in cases of emergency, was read. It was explained that this matter had been taken up with the Corps Area Surgeon following receipt of complaints from physicians residing in the vicinities of several CCC camps in Ohio.

Correspondence and resolutions from the Medical Society of the District of Columbia were discussed and referred to the Committee on Public Policy.

Correspondence from the Toledo Academy of Medicine accompanied by a statement relative to unethical publicity by hospitals, was discussed and ordered filed.

On *motion* by Dr. Davidson, seconded by Dr. Jenkins and carried, the Council expressed its deep appreciation to Dr. Caldwell, the retiring President, for his unselfish and diligent work during the past year and for his kind and considerate treatment of all members of the Council during his administration.

Dr. Caldwell thanked the Council for its expression of appreciation and for the splendid support and cooperation accorded him during his tenure of office.

There being no further business, the Council adjourned to meet with the House of Delegates on the following day, October 2, at 1:00 P. M.

WITH THE HOUSE OF DELEGATES

The Council met with and as a part of the House of Delegates at the Netherland Plaza on Wednesday, October 2, 1935, at 1:00 P. M., and Friday, October 4, at 9:00 A. M.

FINAL COUNCIL SESSION

The final session of the Council during the 89th Annual Meeting was held Friday morning, October 4, 1935, following the adjournment of the House of Delegates. Dr. Hendershott, newly-installed President, called the meeting to order. On *motion* by Dr. Kirkland, seconded by Dr. Jenkins and *carried*, Dr. C. C. Sherburne, Columbus, newly-elected Councilor from the Tenth District, was elected secretary of Council for the ensuing year.

On *motion* by Dr. Brush, seconded by Dr. Klotz and *carried*, the President was authorized to appoint a special committee to consider questions pertaining to the publication of the *Ohio State Medical Journal* and report to the Council at its next meeting to be held in December, 1935.

There being no further business, the Council adjourned to meet at the call of the President.

Signed: JAMES A. BEER, M.D.,
Acting Secretary of Council.

— OSMJ —

Second Annual Medical Institute at the University of Toledo, November 8

The second annual Medical Institute of the University of Toledo will be given on Friday, November 8, 1935, in the Doermann Auditorium at the University.

The meeting is under the direction of Dr. Fred M. Douglass, Dr. B. J. Hein, Dr. John T. Murphy and Mr. Philip C. Nash, President of the University.

The program consists of a symposium on cardiovascular renal disease, conducted by two outstanding physicians and lecturers, Dr. Paul Dudley White, assistant professor of medicine, Harvard University Medical School, and Dr. Alfred Stengel, professor of medicine, University of Pennsylvania, School of Medicine. Lectures will be given at 10:00 A. M., 1:30 P. M. and 8:00 P. M.

This annual medical program, sponsored by the University of Toledo, is made possible through a bequest of the retiring Board of Trustees of the old Toledo Medical College.

A cordial invitation to attend the meeting is extended to all members of the medical profession. There is no registration fee.

— OSMJ —

December Medical Board Exams

Examinations for licenses to practice medicine and surgery and the limited branches of medicine in Ohio will be conducted by the State Medical Board, December 3, 4 and 5, at the Deshler-Wallick Hotel in Columbus. Practical examinations will be given at St. Francis Hospital.

EXCEPTIONALLY FINE PROGRAM, AN EXCELLENT SCIENTIFIC EXHIBIT, LARGE ATTENDANCE AND DEMONSTRATIONS OF INCREASED INTEREST AND ACTIVITY IN ORGANIZED MEDICINE HIGHSPOTS OF 89TH ANNUAL MEETING

THE 89th Annual Meeting of the Ohio State Medical Association held at the Netherland Plaza, Cincinnati, October 2, 3 and 4, deserves to be classed as one of the outstanding meetings in the history of the State Association, both from the standpoint of program and enthusiasm for the work of organized medicine by those attending.

Exceeding all predictions as to registration (1271 members and guests), the attending physicians were generally lavish in their praise of the splendid program, the scientific exhibit, the hard-working and hospitable Cincinnati committeemen, and the luxurious appointments and physical lay-out of the Netherland Plaza, which seemed almost made to order for a state medical meeting.

Two essentials of a successful Annual Meeting are: An interesting scientific program such as that presented at the meeting this year and well organized arrangements. For this too much cannot be said in praise of the Council Committee on Program composed of Dr. Parke G. Smith, Cincinnati, chairman, Dr. C. L. Cummer, Cleveland, and Dr. R. R. Hendershott, Tiffin; and the Council Committee on Arrangements, of which Dr. Smith was also chairman, ably assisted by Dr. E. M. Huston, Dayton, and Dr. I. P. Seiler, Piketon.

BOUQUET FOR DR. SMITH

Any comment on the 89th Annual Meeting would be remiss without a special verbal bouquet for Dr. Smith. As chairman of the above-mentioned committees, he spent months preparing for the meeting. As general chairman of the local committees of the Academy of Medicine of Cincinnati, Dr. Smith was generalissimo of local arrangements. He vowed at the outset that the Scientific Exhibit this year would take its rightful place as one of the features of the Annual Meeting. Under his assiduous sponsorship it did —and one of the most interesting displays in the exhibit was his, in conjunction with Dr. Gordon F. McKim. In addition to these responsibilities, Dr. Smith read a paper before the Surgical Section, and fulfilled his duties as Councilor for the First District and as a member of the House of Delegates.

With such an example set by their general chairman, it was not surprising that the local committees functioned so well. Their efficient and conscientious work in arranging the many details of the meeting was most commendable.

The personnel of the local committees was as follows:

Reception—Edward D. King, president of Academy of Medicine of Cincinnati, *Chairman;* R. S. Austin, M. A. Blankenhorn, Robert Carothers, Robert B. Cofield, Frank M. Coppock, Jr., Hon. Clarence Dykstra, Howard F. Fischbach, Albert H. Freiberg, Alfred Friedlander, Rufus B. Hall, Chas. D. Heisel, Samuel Iglauer, Clarence King, Sidney Lange, Charles J. McDevitt, Gordon F. McKim, A. Graeme Mitchell, E. A. North, F. D. Phinney, Mont R. Reid, F. M. Solar, Chas. T. Souther, Elmore B. Tauber, Hon. Raymond Walters, Hon. Russell Wilson, Henry L. Woodward.

Banquet—Louis Feid, Jr., *Chairman;* Francis E. Cunningham, Hugh H. Hengstenberg, Daniel C. Rivers, Emil R. Swepston.

Entertainment—Henry B. Freiberg, *Chairman;* C. E. Hauser, V. B. Roberts, H. H. Vail, Samuel Zielonka.

Clinics—Dudley Palmer, *Chairman,* Lloyd B. Johnston, Associate Chairman; J. F. Bateman, B. N. Carter, Stanley E. Dorst, Joseph Ganim, Ralph W. Good, L. Howard Schriver, E. B. Shewman, Chas. T. Souther, Frank E. Stevenson, David A. Tucker, Jr.

Halls and Meeting Places—Horace F. Tangeman, *Chairman;* D. J. Bradley, Thad. Gillespie, E. A. Kindel, Davis Lillard, Samuel Seltz, Emil Swepston.

Projective Apparatus—Wm. W. Millar, *Chairman;* Jean Stevenson.

Scientific Exhibits—Symmes Oliver, *General Chairman;* Alfred Friedlander, Chairman, Medical College Group; Oscar Berghausen, Joseph Ganim, Geo. Guest, Robert Kehoe, K. V. Kitsmiller, Cecil Striker.

Commercial Exhibits—Otto J. Seibert, *Chairman;* B. E. Boyer, H. Jerry Lavender, Emil R. Swepston, H. H. Vail.

Publicity—Carl A. Wilzbach, *Chairman;* J. W. McCammon, Robert Rothenberg, Jerome Zeigler.

Women Physicians' Entertainment — Helena Ratterman, *Chairman;* Marion Abbott-Boyd, S. Bertha Dauch, Vera Norton.

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LATEST advances in their respective fields were discussed by approximately 100 Ohio physicians who participated as essayists or discussants in the programs of the scientific sections. The section sessions were well attended and the programs well received.

Out-of-state speakers appearing on the sectional programs were: Dr. H. F. Helmholz, Mayo Clinic, Rochester, Minn., who read a paper on "Chronic Ulcerative Colitis in Childhood" before the Section on Pediatrics; Dr. Wm. E. Sauer, St. Louis, Mo., who discussed "Headache of Nasal Origin", Dr. Sanford R. Gifford, Chicago, who spoke on "The Practical Use of Bacteriology by the Opthalmologist", before the Eye, Ear, Nose and Throat Section, and W. G. Workman, National Institute of Health, Washington, D. C., who discussed "The Status of Serums and Vaccines for

the General Practitioner", at the meeting of the Section on Public Health and Preventive Medicine.

The splendid programs arranged were a distinct tribute to the hard work of the section officers, namely: *Medical*, Dr. H. W. Gauchat, Canton, chairman, Dr. H. C. King, Lakewood, secretary; *Surgical*, Dr. Verne A. Dodd, Columbus, chairman, Dr. Max M. Zinninger, Cincinnati, secretary; *Obstetrics and Gynecology*, Dr. J. K. Hoerner, Dayton, chairman, Dr. James M. Pierce, Cincinnati, secretary; *Pediatrics*, Dr. I. H. Kass, Toledo, chairman, Dr. Hugh Foster, Toledo, secretary; *Eye, Ear, Nose and Throat*, Dr. H. V. Dutrow, Dayton, chairman, Dr. O. J. Walker, Youngstown, secretary; *Nervous and Mental Diseases*, Dr. C. C. Kirk, Orient, chairman, Dr. F. C. Wagenhals, Columbus, secretary; *Public Health and Preventive Medicine*, Dr. J. D. Boylan, Milford Center, chairman, Dr. Emery R. Hayhurst, Columbus, secretary.

GENERAL SESSIONS QUITE POPULAR

The general sessions this year were unusually good and exceptionally well-attended.

Owing to the serious condition of his daughter-in-law, Mrs. Genevieve Forbes Herrick, who was injured near Vellarde, N. M., August 31, in the automobile accident in which Mrs. Harold L. Ickes, wife of the Secretary of the Interior, was killed, James B. Herrick, Chicago, was unable to appear on the program of the Second General Session, as scheduled. However, Dr. Marion A. Blankenhorn, Department of Medicine, College of Medicine, University of Cincinnati, substituted for Dr. Herrick on short notice, and gave an excellent address on "Rheumatic Fever from the Standpoint of the General Practitioner".

On motion of Dr. J. H. J. Upham, Columbus, those attending the session, voted unanimously to thank Dr. Blankenhorn for so graciously taking Dr. Herrick's place on the program. The session also voted to send an appropriate telegram to Dr. Herrick.

Much favorable comment was heard throughout the meeting on the lecture delivered by Dr. Frank H. Lahey, Boston, on "Newer Advances in Hyperthyroidism and Hyperparathyroidism" at the Third General Session, Wednesday afternoon, to a capacity audience.

PRESIDENTIAL ADDRESSES MADE

At the Wednesday evening general session the addresses of the President and President-elect were delivered by Dr. John A. Caldwell, Cincinnati, and Dr. R. R. Hendershott, Tiffin, respectively. (These addresses appear in full elsewhere in *The Journal*).

Dr. Clyde L. Cummer, Cleveland, Past-President, in a few well-chosen words, lauded Dr. Caldwell for his successful administration and presented to him the Past-President's gavel, which is a replica of the official gavel used by the presiding officer at meetings of the House of Delegates.

The guest speaker Wednesday evening was Dr. Morris Fishbein, Chicago, editor of *The Journal of the American Medical Association*. Discussing "Medicine in the Changing Social Order", Dr. Fishbein gave an interesting, instructive and entertaining address.

Dr. Fishbein pointed out the amazing change that has come about in American life in the past 50 years, with the resultant submergence of the individual human being by the developments of science and invention. He pictured the complications of American home life brought on by the invention of automobiles, radios, motion pictures, kitchenette apartments, sophisticated foods, etc.

ADDRESS BY DR. FISHBEIN

Commenting on the increasing cost of medical care, Dr. Fishbein said:

"In a previous generation the child or the adult when sick was cared for in the home. During the past fifty years medical care has been moved out of the home and into the hospital. In 1873 there were 149 hospitals in the United States with 35,000 beds. Today there are almost 7,000 hospitals with almost a million beds. In 1920 we had one hospital bed for every 340 people. Today we have one bed for 270 people.

"The doctor of an earlier day was the one significant factor in the care of the sick. Today there are at least 1,500,000 people in the United States who give their full time to the care of the sick, including doctors, medical office workers, dentists, dental hygienists, assistants, and technicians, physical therapy technicians, *X*-ray technicians, laboratory technicians, osteopaths, naturopaths, chiropractors, Christian Science practitioners and peculiar cultists, trained nurses, practical nurses, midwives, hospital superintendents, record clerks, orderlies, ambulance drivers, cooks, dietitians, optometrists, chiropodists, masseurs, and pharmacists, as well as social workers and the personnel of health departments.

"The increased number of those practicing medicine and the cost of maintenance of innumerable medical institutions has resulted in increasing the cost of medical service. Yet medical care today is worth far more than the medical care of a previous generation. It has extended life expectancy at birth from 40 years to 60 years. It rehabilitates and makes useful citizens out of the crippled, the blind and the hard of hearing, and it provides scientific care for the mentally defective.

"Modern medicine has freed human beings from the fear of disease, and by education of the public, more and more people have come to realize its benefits."

Dr. Fishbein stated that it was not surprising that difficulties should arise in paying for medical care as the increased demands on the purse of the average citizen, as represented by the new standard of living, has made the average man less capable of meeting increased medical costs. He pointed out that such items as $4,000,000,000 annually for motor cars, $2,000,000,000 for tobacco products, $1,000,000,000 for candy, $1,000,000,000 for gasoline, $2,000,000,000 for motion

pictures and entertainment, $1,000,000,000 for soft drinks, ice cream and chewing gum, $1,000,000,000 for perfumes and cosmetics, and still another $1,000,000,000 for sporting goods, toys and radios did not appear in the budget of 1900.

"Coupled with installment-buying and modern advertising, the inducement of expenditure for luxury items is such that more and more families find themselves in difficulties when confronted with meeting costs of such essentials as food, fuel, clothing, housing and medical and dental care," declared Dr. Fishbein.

"The importance of advertising in urging consumption is best reflected in relationship to the sale of cigarets. The first advertisement showing a woman holding a cigaret appeared in 1919; but in 1929 women's consumption represented 12% of the total consumption of cigarets. The amount spent for advertising cigarets in 1931 was $15,000,000."

In conclusion Dr. Fishbein made the following significant statement:

"The American public must be educated to the fact that good health and freedom from fear of disease is more necessary to happiness than any of the items on which it now spends far too great funds. There is a tendency in some places to take away from the individual citizen the responsibility for spending his own money. More and more this tendency has developed in foreign countries where the state takes from the citizen's earnings enough money to insure him against ill health, death, childbirth, or other exigencies of living.

"Today in the United States there is a determined effort to put medicine on the same basis as education, and protection against fire and crime. These efforts arise in the minds of engineers used to dealing with machines that are not human but mechanical. The physician knows that the human machine cannot live successfully if placed on the same basis as an engine or a motor. Human beings are individuals and when they lose their individuality, the spirit and humanity of life goes with it.

"No nation in the world has yet made a success of the socialization of medical care, and even compulsory sickness insurance, after fifty years of experience in Germany and twenty-two years in Great Britain, is still an experiment, undergoing material changes. No doubt, the social order in America will be modified to meet the changes brought about by new inventions and new discoveries, and there will be new developments in the distribution of medical care and in the methods of payment for it. But regardless of these factors, the fundamental individual relationship of doctor to patient will have to be maintained in any system or that system will fail."

FINAL SESSIONS WELL-ATTENDED

The fine attendance at general sessions continued on Thursday afternoon, when Dr. R. Wesley Scott, Cleveland, discussed "Some Practical Considerations of Heart Disease"; Dr. Leslie L. Bigelow, Columbus, spoke on "A Surgical Causerie" and a program was presented by the following members of the Faculty of the College of Medicine, University of Cincinnati: Drs. A. R. Vonderahe, Wm. M. Millar, Stanley E. Dorst, Leon Schiff and Mr. Glenn E. Cullen.

At the last general session held Friday morning after the final meeting of the House of Delegates, Dr. Palmer Findley, Omaha, Nebraska read a paper on "Cancer of the Cervix".

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BOTH sessions of the House of Delegates, Wednesday afternoon and Friday morning, were well-attended, and the proceedings conducted efficiently and promptly.

At the initial session, Wednesday afternoon, Dr. Edward D. King, president of the Academy of Medicine of Cincinnati, welcomed the visiting physicians and presented Dr. John A. Caldwell, Cincinnati, president of the State Association, who called the House of Delegates to order and presided.

COMMITTEE APPOINTMENTS

The principal business of the first session consisted of reports of standing and special committees, officers and Council (published in full in the October issue of *The Journal*); appointment of reference committees; election of the Nominating Committee and introduction of resolutions.

The following were appointed to the various reference committees by Dr. Caldwell:

Resolutions: Dr. J. Craig Bowman, Upper Sandusky, chairman; Dr. D. C. Houser, Urbana; Dr. Lester Taylor, Cleveland; Dr. Otto J. Seibert, Cincinnati, and Dr. Sidney McCurdy, Youngstown.

Annual Address of President and President-Elect: Dr. C. W. Waggoner, Toledo, chairman; Dr. W. W. Sauer, Marietta; Dr. I. B. Harris, Columbus; Dr. Ralph H. Smith, Lancaster, and Dr. R. D. Herlinger, Warren.

Annual Reports of Standing and Special Committees: Dr. J. E. Tuckerman, Cleveland, chairman; Dr. John A. Fraser, East Liverpool; Dr. L. Howard Schriver, Cincinnati; Dr. R. C. Paul, Wooster, and Dr. Robert Conard, Wilmington.

Credentials: Dr. D. J. Slosser, Defiance, chairman; Dr. Foster Kiser, Tippecanoe City, and Dr. A. O. Peters, Dayton.

Tellers and Judges of Elections: Dr. M. O. Cook, Butler, chairman; Dr. B. L. Good, Van Wert, and Dr. G. G. Hunter, Ironton.

The House of Delegates elected the following Nominating Committee consisting of one delegate from each of the ten councilor districts: *First district,* Dr. Otto J. Seibert, Cincinnati; *second district,* Dr. H. C. Messenger, Xenia; *third district,* Dr. E. H. Porter, Tiffin; *fourth district,* Dr. John F. Wright, Toledo; *fifth district,* Dr. R. B. Wynkoop, Ashtabula; *sixth district,* Dr. F. C. Potter, Akron; *seventh district,* Dr. W. L. Davis, Martins Ferry; *eighth district,* Dr. Geo. F. Swan, Cambridge; *ninth district,* Dr. C. F. Shonk, Logan; *tenth district,* Dr. John B. Alcorn, Columbus.

DR. HUSTON, NEW PRESIDENT-ELECT

At the second and final session of the House of Delegates, Dr. E. M. Huston, Dayton, Councilor

from the Second District, was elected President-elect, and Dr. R. R. Hendershott, Tiffin, was installed as President for the ensuing year.

The following Councilors were elected for their respective districts: Dr. D. W. Hogue, Springfield, second district; Dr. B. J. Hein, Toledo, fourth district; Dr. W. M. Skipp, Youngstown, sixth district; Dr. E. R. Brush, Zanesville, eighth ditsrict, and Dr. C. C. Sherburne, Columbus, tenth district.

Dr. Hendershott announced the following committee appointments: Dr. Charles W. Stone, Cleveland, Public Policy (three years); Dr. F. P. Anzinger, Springfield, Medical Defense (three years); Dr. Wm. H. Bunn, Youngstown, Medical Education and Hospitals (three years); and Dr. L. Howard Schriver, Cincinnati, Medical Economics.

The present delegates and alternates to the American Medical Association annual meeting whose terms expired this year were re-elected for two years. They are: Dr. J. P. DeWitt, Canton, delegate, Dr. G. F. Zinninger, Canton, alternate; Dr. C. E. Kiely, Cincinnati, delegate; Dr. L. H. Schriver, Cincinnati, alternate; Dr. C. W. Waggoner, Toledo, delegate and Dr. Charles Lukens, Toledo, alternate.

Invitations were received from the Cleveland Academy of Medicine to hold the next Annual Meeting in Cleveland, and from the Erie County Medical Society to meet at Cedar Point. The House of Delegates chose Cleveland.

It was decided that the time of the next year's meeting, either in the Fall or Spring, should be determined following a referendum vote by the county societies and local academies.

The official minutes of the sessions of the House of Delegates will be found on pages 855 to 866 in this issue of *The Journal*.

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APPROXIMATELY 500 physicians and guests enjoyed the annual banquet held in the beautiful Hall of Mirrors of the Netherland Plaza Thursday night. Dr. A. Graeme Mitchell, Cincinnati, the toastmaster, was very adept at introducing the various speakers. The Hon. Russell Wilson, Mayor of Cincinnati, welcomed the visiting physicians to the Queen City—even to the extent of permitting them to use his name in case they got into trouble.

In presenting "Highlights of the First State Medical Meeting Held One Hundred Years Ago", Dr. Jonathan Forman, Columbus, reviewed the proceedings of the meeting held in Columbus January 5, 1835. He related some of the transportation difficulties encountered by physicians who went to the first state meeting, including stages overturned, horses frightened by wolves, etc., and how Dr. Peter Allen, one of the outstanding physicians of the Western Reserve and the one who was elected president of the convention, made the trip to Columbus from his home in Trumbull County on horseback, taking one week to go and one week to return; so that he was away from home attending "the state meeting" just three weeks.

REVIEW OF FIRST MEDICAL MEETING

Dr. Forman said that out of this meeting came at once the State School for the Blind and the Central Lunatic Asylum, projects sponsored by Dr. Wm. Awl, Columbus, one of the founders of American psychiatry, who called the meeting.

Among the items for the convention's consideration listed in the announcement of the meeting, were: regulation of professional etiquette; construction of independent medical societies; support of a periodical journal of practical medicine; erection and location of public asylums for the reception of lunatics and the instruction of the blind; promotion of the temperance cause; regulation of vaccination; and the convenient supply of leeches.

In relating the accomplishments of this first state medical meeting, Dr. Forman said:

"Indirectly, the profession received great benefit from the groundwork that was laid for the formation of local medical societies and for a national medical society. Then too, for the first time the physicians of the state had a definite code of ethics".

CHICAGO PROFESSOR IS GUEST SPEAKER

The guest speaker at the annual banquet was Dr. Gordon J. Laing, dean of the Division of Humanities, University of Chicago, and editor of the University of Chicago Press.

Dr. Laing, who admitted he is a doctor of philosophy and not of medicine, confessed at the outset that his subject, "Are Doctors Human?" was an unhappy choice. He said:

"It is a most difficult question, because there are so many kinds of doctors—allopaths, osteopaths, homeopaths, any number of 'paths', and all lead but to the grave".

Speaking, as a Cincinnati newspaper reporter said, "in a circle of witticisms", Dr. Laing entertained his audience for an hour with some of his personal experiences with physicians, including the story of his tonsillectomy, which he described as "deep sea dentistry".

In concluding his address Dr. Laing said that physicians are prone to become so involved in the scientific ramifications of their work, that they lose interest in music, art, social activities, and even politics.

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AN INNOVATION, which it is hoped will become a permanent feature of subsequent Annual Meetings, was a luncheon given by the State Association, Thursday, for all Past-Presidents of the Association.

It was recalled by some of the Past-Presidents

present that Dr. Wells Teachnor, Columbus, and Dr. Robert Carothers, Cincinnati, were hosts to the Past-Presidents at a dinner during the 76th Annual Meeting of the State Association held in Columbus, May 2, 3 and 4, 1922.

While no definite program was arranged, a round-table discussion following the luncheon brought forth some excellent suggestions on organization matters from these physicians who at one time were at the helm of organized medicine in Ohio.

The following Past-Presidents attended the luncheon: Dr. Ben. R. McClellan, Xenia, 1906-07; Dr. Wm. E. Lower, Cleveland, 1915-16; Dr. Wells Teachnor, Columbus, 1921-22; Dr. Robert Carothers, Cincinnati, 1922-23; Dr. Joseph S. Rardin, Portsmouth, 1923-24; Dr. L. L. Bigelow, Columbus, 1927-28; Dr. Charles W. Stone, 1928-29; Dr. Albert H. Freiberg, Cincinnati, 1929-30; Dr. C. W. Waggoner, Toledo, 1930-31; Dr. D. C. Houser, Urbana, 1931-32; Dr. H. M. Platter, Columbus, 1932-33; Dr. C. L. Cummer, Cleveland, 1933-34, and Dr. John A. Caldwell, Cincinnati, President, and Dr. R. R. Hendershott, Tiffin, President-elect.

Other Past-Presidents present at the 89th Annual Meeting, but unable to attend the luncheon, were Dr. Charles Lukens, Toledo, 1920-21, and Dr. J. H. J. Upham, Columbus, 1914-15, who addressed the Cincinnati Rotary Club Thursday noon.

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A WELL-BALANCED and instructive program of medical and surgical clinics attracted the attention of many physicians at various Cincinnati hospitals on Wednesday morning, October 2.

Dr. Dudley Palmer headed the Clinics Committee of the Academy of Medicine of Cincinnati, responsible for the program of operative and dry clinics.

Cincinnati physicians who participated in the surgical and medical demonstrations included:

General Hospital: Drs. Mont R. Reid, B. N. Carter, Max Zinninger, Marion A. Blankenhorn, Johnson Maguire, Leon Goldman, Louis G. Herrmann, Edward McGrath, A. Graeme Mitchell, Waldo Nelson, Joseph A. Freiberg, Edward D. King, Samuel Seltz, Samuel Iglauer, Ben L. Bryant, Henry Gruener, Louis Safer, Henry Goodyear, S. H. Portnoy, V. S. Roberts, Henry B. Freiberg.

Bethesda Hospital: Drs. J. Stewart Hagen, E. H. Niesen, J. J. Maloney, C. R. Deeds, Frederick Fischer, C. W. Betzner, C. S. Amidon, C. E. Schrimpf.

Children's Hospital: Dr. H. H. Haggart.

Good Samaritan Hospital: Drs. J. D. Miller, Jos. DeCourcy, C. S. Roof, Eslie Asbury, W. D. Haines.

Jewish Hospital: Drs. Sam Zielonka, Jos. Ransohoff, A. L. Grollman, J. R. Stark, E. O. Swartz, A. Brown, Sam Seltz.

St. Mary's Hospital: Dr. Walter Griess, Dr. C. E. Schrimpf.

Deaconess Hospital: Drs. S. H. Portnoy, R. W. Good, B. R. Sackler, A. Fleming, S. Weinstein.

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THE commercial exhibits at the 89th Annual Meeting were unusually fine and well-patronized. The exhibitors were particularly pleased with the location of their booths in the South Exhibit Hall, adjacent to the Hall of Mirrors, in which all the general sessions were held. A list of the commercial exhibitors follows:

A. S. Aloe Company, St. Louis; Bard, Parker Co., Inc., Danbury, Conn.; Bilhuber-Knoll Corporation, Jersey City, N. J.; Cameron Surgical Specialty Co., Chicago; Davies, Rose & Co., Ltd., Boston; H. G. Fischer & Co., Inc., Chicago; General Electric X-Ray Corporation, Chicago; Gerber Products Co., Fremont, Mich.; The Heidbrink Co., Minneapolis; H. J. Heinz Co., Pittsburgh; Horlicks Malted Milk Corporation, Racine, Wisc.; Hynson, Westcott & Dunning, Baltimore, Md.; Kelly-Koett Manufacturing Co., Covington, Ky.; Lea & Febiger, Philadelphia; Lederle Laboratories, New York City; The Liebel-Flarsheim Company, Cincinnati; Mead Johnson & Company, Evansville, Ind.; Medical Protective Co. of Ft. Wayne, Ind., Wheaton, Illinois; Mellin's Food Company, Boston; Merck & Co., Inc., Rahway, N. J.; The Wm. S. Merrell Company, Cincinnati; M. & R. Dietetic Laboratories, Columbus; Philip Morris & Company, New York City; C. V. Mosby Company, St. Louis; Petrolagar Laboratories, Inc., Chicago; S. M. A. Corporation, Cleveland; U. S. Standard Products Co., Woodworth, Wisconsin; The W. T. Wagner's Sons Co., Cincinnati; The Max Wocher & Son Company, Cincinnati.

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MUCH credit for the way the physical arrangements for the meeting were handled should go to the efficient and courteous staff of the Netherland Plaza. The service of the hotel management and staff was excellent and a big help in keeping the meeting moving at top-speed.

The Cincinnati Chamber of Commerce is also entitled to a vote of thanks for furnishing the necessary clerical help and information service at the Registration Headquarters.

Press reports of the meeting were exceptionally fine, due to the excellent cooperation of the Cincinnati newspapers.

In fact, the splendid cooperation and hospitality of all Cincinnatians who had anything to do with the 89th Annual Meeting brought many expressions of appreciation from the visiting physicians.

SECRETARY OF STATE INDUSTRIAL COMMISSION ADDRESSES ORGANIZATION LUNCHEON AT CINCINNATI MEETING

APPROXIMATELY 150 attended the Organization Luncheon held on Friday—the last day of the 89th Annual Meeting, at Cincinnati, for the officers, past-presidents, councilors and committee members of the State Association; delegates to the American Medical Association; the presidents, secretary-treasurers, legislative and medical defense committeemen, correspondents to *The Journal* of the county medical societies; members of the House of Delegates; section officers and chairmen of the Cincinnati committees on arrangements.

Dr. R. R. Hendershott, Tiffin, the incoming president, presided as chairman. Seated with him at the seakers' table were Dr. John A. Caldwell, Cincinnati, the retiring president; Dr. E. M. Huston, Dayton, president-elect, and the Hon. A. D. Caddell, secretary of the State Industrial Commission.

Dr. Hendershott briefly welcomed the physicians to the Organization Luncheon, and called their attention to a communication over his signature which had been distributed to them requesting their continued cooperation during his administration as president of the State Association, and emphasizing the necessity of their active interest in the important responsibilities for which they had been selected. Dr. Hendershott's communication read as follows:

GREETING FROM THE PRESIDENT

"It is an honor and privilege to welcome you, through this communication, to the 1935 Organization Luncheon of the Ohio State Medical Association.

"You have been invited to participate in this event because of your active interest in the functions of organized medicine. You have been given this opportunity to become better acquainted with others upon whom the medical profession of this state is counting to assume the responsibilities of leadership in medical organization during the ensuing months.

"Every organization must have its key-men. Those assembled here today are regarded as such.

"The success of every organization depends to a degree on the quality of its leadership. You and your colleagues will be expected to produce the kind of leadership that will insure new achievements and substantial progress on the part of medical organization.

"If we do our work well and work together, the standing of our organization will be enhanced; its achievements more numerous.

"None of us can accomplish hoped-for results without the help of others in equally strategic positions. Much that we plan and initiate will fail unless we secure the active assistance of the rank and file—the real force which keeps the machinery of medical organization in operation.

"Therefore, the first big responsibility confronting us is to arouse the membership generally to taking a greater interest in the work of medical organization.

"In other words, we must undertake the task of "re-selling" medical organization to many of its own members.

"Let us put more members to work. In my opinion, the easiest way to win the enthusiasm and support of a member in any organization is by giving him something to do; delegating to him some responsibility; appealing to his pride by letting him know he will be expected to produce results which will gain him the commendation of his colleagues and broaden the influence of his organization.

"Our second immediate task is to bring about a better correlation of the local and state activities of organized medicine.

"We should work in unison. There should be an exchange of ideas and information. Let us help each other. Make use of our State Headquarters Office. Use it as a clearing house and means of coordinating our activities.

"Those assembled in this room today have the ability and influence to lead the Ohio State Medical Association to bigger and better things.

"Progress can be made through cooperation. I am confident you will meet this challenge."

After introducing Dr. Huston, and the newly-elected Councilors, Dr. D. W. Hogue, Springfield, Second District; Dr. Wm. M. Skipp, Youngstown, Sixth District; and Dr. C. C. Sherburne, Columbus, Tenth District, Dr. Hendershott presented the Hon. A. D. Caddell, Secretary of the State Industrial Commission, who spoke on "Administration of the Workmen's Compensation Law in Ohio."

ADDRESS BY MR. CADDELL

In discussing the problems of the Commission, Mr. Caddell pointed out that from the time of the passage of a "ripper bill" in 1921 until May 15, 1934, control of the personnel of the Industrial Commission had been vested in the Department of Industrial Relations, an arrangement which was a distinct handicap to the Commission and a cause of great confusion and difficulty.

He stated that the present Commission is making an earnest effort to improve the efficiency of the department and to eliminate unsatisfactory conditions which had arisen in previous years.

"Ohio will never have adequate administration of the Workmen's Compensation Law until the Commission is given proper tools," Mr. Caddell declared, citing the fact that the Commission is greatly undermanned.

He pointed out that while the state of New York used 37.6 per cent per dollar of premium for administration of its Workmen's Compensation Law, Ohio uses only 8.4 per cent.

Commenting on the reports of the Bush Committee, appointed by Governor White, and the Sherrill Ohio Government Survey Committee, Mr. Caddell said that the Commission concurred in a majority of the recommendations of these committees.

Mr. Caddell said that as a result of the im-

COUNTY SOCIETIES ASKED TO HAVE MEMBERS VOTE ON TIME FOR 1936 ANNUAL MEETING OF STATE ASSOCIATION

AT THE final session of the House of Delegates during the 89th Annual Meeting of the State Association at Cincinnati, October 2-4 there developed considerable discussion as to whether the 1936 Annual Meeting at Cleveland should be held in the Spring or in the Fall.

Sentiment among the delegates in attendance was almost evenly divided.

The roll call showed that 41 counties were not represented at that session of the House of Delegates. Therefore, those counties had no opportunity to express their preference on the matter of a Spring or a Fall meeting.

Taking these facts into consideration, the House of Delegates voted to let the county medical societies and academies of medicine decide the question. It authorized a referendum to secure information for guidance of the Council in setting the dates for the 1936 Annual Meeting.

On October 11 a communication was sent from the State Headquarters Office, Columbus, to the secretary and the president of each county medical society and academy of medicine requesting them to arrange for a vote on the proposition at the next meeting of the society or academy and transmit the result to the State Headquarters Office.

Some county medical societies already have voted on the question. Those which have not should do so immediately.

This is a matter of particular interest to all members of the State Association and an opportunity for all members to express an opinion on a matter which has provoked considerable controversy.

All members should insist that they be given an opportunity to vote.

It is the duty of all members to attend the meeting at which such action is scheduled and assist in making the referendum a real indication of the views of the membership as to the time of the year for the 1936 Annual Meeting.

provements in administrative procedure, 91% of the claims filed with the Commission are given a hearing in from 10 to 21 days.

"Physicians can greatly expedite the adjudication of claims and payment of bills for medical service to beneficiaries of the Workmen's Compensation Fund, if they will file their reports more promptly and be more careful in furnishing the detailed information required on such reports," Mr. Caddell said.

He pointed out that 25% of the total benefits paid out of the Workmen's Compensation Fund each year goes for medical and hospital fees, and that during the first year after an injury, fees paid for medical and hospitalization service to a claimant are usually three times the amount of compensation paid to him.

DISCUSSES 20% REDUCTION

In discussing the request of the Ohio State Medical Association that the Industrial Commission give immediate consideration to the restoration of the 20% cut in medical fees which was made in the Spring of 1933, Mr. Caddell reviewed the circumstances which necessitated this reduction. He cited the continued economic depression which caused a decrease in the amount of premiums paid into the fund, with little decrease in claims filed, but an increase in revived claims, with the resultant precarious financial condition of the fund. He said that while the financial status of the fund has improved, the Commission would not be in position to give consideration to the restoration of the 20% reduction in medical fees until definite action had been taken on the recommendations of the various investigating committees, and the financial security of the fund assured.

Mr. Caddell said the request of the State Association was a live issue, and that physicians could expect a favorable decision from the Commission just as soon as it felt it could safely do so.

In concluding his address, Mr. Caddell stated that as a result of his investigations in other states, it was his opinion that the Workmen's Compensation Law in Ohio is second to none. He commented on the friendly feeling between the officials of the Ohio State Medical Association and the State Industrial Commission and its executives, and expressed the hope that this cooperation would continue.

DR. J. D. FOUTS, DAYTON, WINNER OF THE CHAMPIONSHIP CROWN OF OHIO STATE MEDICAL GOLFERS AT CINCINNATI

THE Fifteenth Annual Golf Tournament of The Ohio State Medical Golfers' Association was held at the Maketewah Country Club, Cincinnati, on Tuesday, October 1, 1935.

In spite of a chilly, threatening day that kept many a golfer at home the field of players numbered 60 physicians from all sections of the state. And even though the crowd was much smaller than usual yet it more than made up in enthusiastic play what it lacked in numbers. A large comic poster of a golfer with a knowing, sophisticated twinkle in his eye greeted the players at the entrance to the club house. At the bottom of the poster was this query, "Vas You Ever In Zinzinatti?" and before the day was over the cordial hospitality of the local committee made an indelible impression on the physicians, not soon to be forgotten.

Dr. J. D. Fouts, Dayton, is the new champion of the Ohio Medical Golfers. He turned in a morning card of 81 and played the afternoon round in 84 to make a total of 165 strokes for the 36 holes of medal play. Because of illness, Dr. J. J. Marek, Cleveland, winner of the championship last year, was unable to be present to defend his title.

Dr. L. M. Otis, Celina, winner of the championship trophy in 1932, was runner-up with a score of 166, while third low gross was won by Dr. A. K. Buell, Athens, with a score of 169 for the 36 holes. A stiff wind interfered with low scoring.

The Ohio State Medical Journal Trophy, up for its second year of competition, was won by Dr. C. W. Hullinger, Springfield, with a card of 168. This event is open to players 35 years of age and under and was won last year by Dr. A. K. Howell, also of Springfield. Second prize in this event was awarded to Dr. J. J. Harrison, Napoleon, with a score of 174 and third place was taken by Dr. R. E. Hatfield, Cincinnati, with a card of 175.

The State Auto Mutual Insurance Company Trophy, also up for its second year of competition, was won by Dr. A. K. Howell with a card of 85 for the first 18 holes of play. This event is open to players from 36 to 45 years of age. Second prize was won by Dr. J. H. Rinehart, Springfield, with a score of 86. Dr. F. L. Eyestone, Toledo, won third place with a card of 87.

The Buckeye Union Casualty Company Trophy, open to players between the ages of 46 and 55 inclusive and up for its second year of competition, was won by Dr. R. R. Richison, Springfield, with a card of 83 for the first 18 holes of play. Dr. A. C. Smith, Wooster, and Dr. Louis Feid, Cincinnati, were awarded second and third prizes respectively, both turning in a score of 87.

The President's Trophy, awarded for low net first 18 holes-handicap 18 or under, was won by Dr. W. C. Scheidt, Celina, with a net score of 69. Dr. Louis Feid, President for this year, presented a beautiful silver pitcher for the event which is one of the most keenly contested events in each tournament program.

The Grand-Dads Trophy, open to players over 55 years of age and awarded for low gross—first 18 holes, was won by Dr. H. M. Schuffell, Canton, with a score of 91. Second place went to Dr. J. P. De Witt, also of Canton, with a card of 94, while third prize was awarded to Dr. W. D. Inglis, Columbus, with a score of 96.

The Cincinnati Journal of Medicine Trophy, a newcomer to the growing field of events—awarded for low net second 18 holes—18 handicap or under, was won by Dr. J. J. Fay, Cincinnati, with a net score of 64. Dr. C. S. Roof, Cincinnati, took second place with a net score of 68, while Dr. C. A. Price, likewise from Cincinnati, took third prize with a net score of 69.

Dr. H. A. Moore, Oxford, was awarded a beautiful prize for being the golfer who got the most exercise out of the tournament, piling up a total of 120 strokes for high gross score—18 holes of play.

Dr. A. N. Wisely, Lima, won first prize in the Handicap Event, 36 holes low net, with a net score of 138. Other prizes in this event were awarded to Dr. G. R. Micklethwaite, Portsmouth, Dr. C. E. Schrimpf, Cincinnati, Dr. J. F. Wright, Toledo, Dr. T. R. Fletcher, Columbus, Dr. L. D. Stoner, Canton, Dr. M. R. Haley, Dayton, Dr. Chas. Lukens, Toledo, and Dr. J. B. Sampsell, Van Wert.

The Team Championship Trophy, awarded by Dr. J. T. Murphy of Toledo to the city having the aggregate low gross score for 36 holes for any five players, was won this year by the Cincinnati Academy of Medicine.

An extra special prize of a fine leather golf bag was awarded to Dr. S. Schloss, Cincinnati, for the low gross score of the tournament. Dr. Schloss, a "tenderfoot" in the ranks of medicine and at present connected with the Cincinnati General Hospital, was not eligible to compete in the Championship Event. However, he is a golfer of unusual ability and has already earned for himself recognition in national amateur golf circles. His score for the 36 holes of play was 153, with a card of 74 for the morning round and a total of 79 for the second 18 holes of play.

Officers of the Association for next year are as follows: President, Dr. J. B. Morgan, Cleveland. Dr. Morgan, at present in Europe for an extended period of postgraduate study, has for years been Secretary-Treasurer of the Golfers' Association;

First Vice-President, Dr. M. R. Haley, Dayton; Second Vice-President, Dr. F. L. Eyestone, Toledo; Third Vice-President, Dr. F. W. Watson, Columbus; Fourth Vice-President, Dr. J. J. Marek, Cleveland; Fifth Vice-President, Dr. O. P. Tatman, Chillicothe; Secretary-Treasurer, Mr. H. C. Gerber, Jr., Executive Secretary of the Toledo Academy of Medicine. Mr. Gerber for years has been a valuable assistant to local committees on arrangements.

The local committee on arrangements, headed by Dr. Louis Feid, President, and including Drs. Ralph Hatfield, Wesley Furste, C. R. Deeds, C. A. Price, W. H. Ventress and Cyril Schrimpf, was given a rousing vote of thanks and appreciation for the splendid job.

Following are the gross scores and handicaps of the players who participated:

NAME	FIRST NINE	SECOND NINE	HANDICAP
Hullinger, C. W., Springfield	86	82	17
Howell, A. K., Springfield	85	85	10
Rinehart, J. G., Springfield	86	93	13
Richison, R. R., Springfield	83	87	12
Moore, H. A., Oxford	120	105	24
Skinner, D. M., Hamilton	116	101	20
Eyestone, F. L., Toledo	87	86	12
Wright, J. F., Toledo	96	94	25
Lukens, Chas., Toledo	102	88	20
Schuffell, H. M., Canton	91	85	25
Stoner, L. D., Canton	104	91	25
Fouts, J. D., Dayton	81	84	6
Novotny, E. J., Lorain	98	99	14
Haley, M. R., Dayton	87	86	13
Otis, L. M., Celina	84	82	14
Scheidt, W. C., Celina	83	88	14
Lyford, George, Cincinnati	117	112	20
Yingling, W. E., Lima	88	90	9
Anderson, J. G., Fayetteville	104	93	12
Smith, A. C., Wooster	87	91	14
Buell, A. K., Athens	90	79	10
Zeigler, J., Cincinnati	96	88	8
Sprague, J. R., Athens	110	101	16
Sampsell, J. B., Van Wert	97	90	18
McConagha, A. B., Columbus	107	98	25
Fletcher, T. R., Columbus	99	94	25
Yingling, E. C., Lima	91	82	12
Seibert, O. J., Cincinnati	93	104	18
Johnson, J. R., Lima	109	100	25
Wiseley, A. N., Lima	91	91	22
Micklethwaite, G. R. Portsmouth	93	96	25
Harrison, J. J., Napoleon	82	92	8
Feid, Louis, Cincinnati	87	—	16
Deeds, C. R., Cincinnati	97	—	18
Schloss, S., Cincinnati	74	79	4
Foster, R. J., New Philadelphia	101	—	25
Palmer, C. S., Massillon	90	—	74
Inglis, W. D., Columbus	96	91	18
Hatfield, R. E., Cincinnati	84	91	11
Berkley, S. B., Canton	91	95	11
DeWitt, J. P., Canton	94	—	23
Fay, J. J., Cincinnati	88	82	18
Price, C. A., Cincinnati	89	87	18
Schrimpf, C. E., Cincinnati	90	84	18
Cook, R. Harvey, Oxford	104	103	18
Secrest, H. E., Columbus	102	89	18
Ventress, W. H., Cincinnati	100	—	18
Wilkinson, R. R., Cincinnati	94	—	84
Renneker, A. F., Cincinnati	106	95	18
Roof, C. S., Cincinnati	92	82	14
Cook, L. E., Cincinnati	108	—	18
Ross, A. C., Cincinnati	109	—	18
Fischbach, V. W., Cincinnati	93	—	18
Beck, T. J., Cincinnati	95	—	18

(The following score cards were not turned in):

White, H. E., Columbus
C. J. McDevitt, Cincinnati
Moore, E. F,, Cincinnati
Bradley, D. J., Cincinnati

COUNTY SOCIETIES URGED TO AID LOCAL RELIEF OFFICIALS IN PROVIDING MEDICAL PLAN FOR CARE OF POOR; PROMPT COOPERATION IN WPA INJURY PROCEDURE ESSENTIAL

ON October 15, allotment of federal funds for direct relief had been discontinued in 36 Ohio counties, and unless there is a reversal on the policy of the Federal Emergency Relief Administration, the Federal Government will entirely withdraw from direct relief in Ohio on November 1.

Complete responsibility for the care of Ohio's indigent will then devolve on the state and local political subdivisions.

This policy of FERA is based on the expectation that 200,000 Ohio employables on relief would be absorbed by projects of the Works Progress Administration, the Public Works Administration and private industry by November 1. However only 30,000 have actually been put to work as this issue of *The Journal* goes to press and it has been intimated in the newspapers that the Federal Government may continue to furnish direct relief for employables until they have been assigned to works projects.

This conjecture is unofficial, however, and should not cause local authorities to hold up plans now being formulated for the administration of poor relief.

In many Ohio counties a centralized program of administering relief under the supervision of the county commissioners has already been worked out. Most of these counties are taking over the existing personnel in FERA offices, who have had experience and training in relief work.

LOCAL ACTION IS IMPERATIVE

As emphasized in recent issues of *The Journal*, it is highly important that officers of the county societies and local academies make proper contact immediately with county commissioners, township trustees, etc., so that new provisions for medical care of the indigent will be satisfactory to the medical profession.

It has been estimated that $23,000,000 will be required in Ohio for the care of 56,000 families in the unemployable class and supplemental relief to WPA employes from November 1, 1935 to December 31, 1936, and that only $10,000,000 of this amount can be raised through the issuance by the counties of poor relief bonds under the Carey

Act. The Governor and the Legislature have as yet been unable to agree on a plan to provide the additional funds said to be required.

SOME COUNTY SOCIETIES NEGLIGENT

At the suggestion of the Ohio State Medical Association, a letter was addressed on August 28 to officers of the county medical societies and local academies by C. C. Stillman, then WPA Administrator in Ohio, requesting that they file with Glen I. Hay, State WPA Compensation Officer, a list of their members who wished to render medical service, under the regulations of the United States Employes' Compensation Commission, to employes injured on WPA projects.

Findlay physician, will be WPA Administrator for Ohio, succeeding Chas. C. Stillman, who will return to the faculty of Ohio State University. In addition to his WPA duties, Mr. Stillman has been in charge of FERA activities in Ohio since last March.

PROPER WAY TO PREPARE FORMS

According to the United States Employes' Compensation Commission, difficulty is being experienced in the settlement of some claims for medical services to injured WPA workers, because some physicians are not submitting vouchers prepared in proper form and because they are

SAMPLE VOUCHER

The United States, Dr., To Richard M. Roe, M.D.
210 Medical Building, Chicago, Ill.

Date or period of treatment	Name of employe and nature of injury	Character of services or supplies	Quantity or number	Unit price Cost per	Amount Dollars	Amount Cts.
Sept. 1-5 1935	John Doe Forest Service	Suture wound 9/1/35	1	3.00	3	00
	Laceration palm rt. hand	Dressing 9/2/35	1	1.00	1	00
		Dressing 9/5/35	1	1.00	1	00
I certify that the services covered by this voucher were rendered as claimed. (*Signature of Compensation Officer*) State your title here						
				TOTAL	5	00

I certify that the above bill is correct, etc.
Payee Richard M. Roe Per.....
(*Signature of Physician*) Title.....

CERTIFICATE OF INJURED EMPLOYE

I certify that the above-mentioned services and/or supplies were received by me, etc.

(Sign Original only) John Doe
(*Signature*)

On October 17 lists had been received from the following counties:

Perry, Greene, Guernsey, Fayette, Brown, Vinton, Warren, Fulton, Adams, Ashland, Hamilton, Auglaize, Trumbull, Jackson, Miami, Pike, Muskingum, Columbiana, Allen, Ashtabula, Wood, Hardin, Montgomery, Clermont, Delaware, Geauga, Crawford, Summit, Fairfield and Putnam.

It is hoped that the remaining county medical societies will comply with this request immediately, so as to facilitate the work of Mr. Hay's department and make it possible for all physicians desiring this type of work to be on the authorized lists.

After November 1, Dr. Carl Watson, retired

sending them to Washington instead of to the local WPA compensation representative.

Rules and regulations covering this service were explained in detail in the September issue of *The Journal*, pages 701-3.

It is suggested that all physicians rendering WPA medical service note carefully the following instructions when submitting charges on voucher Form S-69, which, when completed, *should be sent to the local compensation officer—and not to the U. S. Employes' Compensation Commission:*

1. Attach authorization for treatment or examination (Special Form CA-16 or CA-17) if it has not already been forwarded to the Commission.

2. AN UNITEMIZED BILL CANNOT BE PAID. The account must be stated in sufficient detail to show clearly the service rendered. The date of each treatment, including year and date and the charge therefor is required.

3. Medicine and drugs supplied from the physician's own stock may be allowed *only* when such item bears the notation "Supplied from stock." If not supplied from physician's own stock, a receipt therefor is required, otherwise item will be disregarded.

4. DO NOT INCLUDE CHARGES FOR SERVICES RENDERED BY OTHERS unless the person rendering such services was a salaried employe in your employ. Claim for payment for services rendered by others than your salaried employe must be made on a separate voucher by the person who rendered such services. If you have paid another person for services rendered on your order, the amount so paid may be included in your voucher if accompanied by an itemized bill properly receipted.

5. Signature of injured employe must be affixed to voucher. If signature is by mark, it must be witnessed by a person other than payee and must bear full signature and address of witnesses. If signature of employe cannot be obtained, explain why.

6. Special information required:

(a) *X*-rays—Date of *X*-ray, number of views and parts of body *X*-rayed. *X*-ray negatives should not be sent to the Commission unless specifically requested by the Commission.

(b) Hospitals—Allowance will be made for the day of admission but *not* for the day of discharge. The per diem rate includes: General medical and surgical care by the house staff, ordinary nursing, usual medicines, dressings and supplies, routine laboratory tests, and material for plaster casts.

(c) Bills for hospital service, nurses, consultants, *X*-rays, anesthetic, medicine, appliances, physiotherapy, drugs, etc., must be approved by the physician in charge.

7. All vouchers must be endorsed by the Local Compensation Officer or in case of Federal establishments the official superior of the injured employe. (See Sample Voucher.)

—OSMJ—

Dr. Upham on A.M.A. Committee

Dr. J. H. J. Upham, Columbus, chairman of the Committee on Public Policy of the Ohio State Medical Association, and who retired as chairman of the Board of Trustees of the American Medical Association last June, was recently appointed a member of the Committee on Legislative Activities of the A.M.A.

—OSMJ—

W. L. Howard, assistant director of the University Hospitals, Cleveland, has been named superintendent of the Akron City Hospital, succeeding Arden E. Hardgrove, who will become assistant executive secretary of the American Hospital Association, Chicago, December 1.

SCIENTIFIC EXHIBIT OF 41 DISPLAYS FEATURE OF ANNUAL MEETING

ONE of the outstanding features of the 89th Annual Meeting was the Scientific Exhibit —the most elaborate and extensive in the history of the state association. The entire north exhibit hall of the Netherland Plaza was required to house the 41 exhibits.

Praise of the highest order is due Dr. Symmes Oliver, general chairman of the Committee on Scientific Exhibits, Dr. Alfred Friedlander, chairman of the Medical College group, and the other members of the committee, namely; Drs. Oscar Berghausen, Joseph Ganin, Geo. Guest, Robert Kehoe, K. V. Kitsmiller, and Cecil Striker, as well as Dr. Parke G. Smith, Cincinnati, program chairman, for arranging this most interesting and educational display.

It was generally agreed by those who viewed this splendid exhibit that the Association should take steps to provide an equally good exhibit at each state meeting.

The following is a complete list of the scientific exhibits:

The Skin Manifestations and Treatment of Syphilis—by Dr. C. L. Cummer and Dr. C. G. La Rocco, Cleveland.

Prevcntive Procedures in Infancy—by Drs. T. K. Selkirk, J. V. Greenebaum, B. K. Rachford and L. W. Rauh, Cincinnati.

Epidemiology of the Common Cold—by Dr. J. A. Doull, Western Reserve University, Cleveland.

Correlation of Roentgenology and Pathology of Thorax—by Dr. H. B. Davidson, Ohio State University, Columbus.

Closed Method for Encephalography—by Dr. H. D. Piercy, Cleveland.

Combating Tuberculosis—by Dr. Theodore L. Bliss, Edwin Shaw Sanatorium, Akron.

Demonstration of Action of Dacryor-rhetin (Motion Picture, with Kodachrome Film)—by Dr. Shiro Tashiro, Cincinnati.

Sight Saving Classes (Cincinnati Public Schools)—by Heberle School, Cincinnati.

Oral School for the Deaf—Cincinnati.

Allergy Exhibit—by Cleveland Allergy Society, Cleveland.

Life Masks and Anatomic Models—by Dr. Samuel Iglauer, Cincinnati.

Burns, Pathology and Treatment—by Dr. D. J. Kindel, Cincinnati.

Medical Classics Illustrating the History of Medicine—by Dr. David A. Tucker, Cincinnati.

Peripheral Vascular Diseases (Paveax)—by Dr. Louis G. Hermann, Cincinnati.

Chronic Lung Diseases (X-ray exhibit and pathologic specimens)—by Hamilton County Tuber-

Readily ASSIMILABLE FAT -- an essential in FEEDING THE PREMATURE

IN a recent study of fat metabolism in infants, Holt, Tidwell and Kirk* report that olive oil showed the highest percent retention (95.1%) of all fats studied but one, olein (97.5%). These authors found the fat of SIMILAC (which is 20% olive oil) showed a better percent retention (92.6%) than butter fat (88.9%)—and as high a retention as breast milk fat (92.4%).

To quote these authors—"the differences in fat retention on these various fats as shown on normal infants are not great; for the normal infant it is probably immaterial whether he absorbs 85% or 95% of his fat intake. It seemed possible, however, that *in subjects who have difficulty in fat assimilation, such as premature infants, the observed small differences might become large differences. A few observations made on premature infants and twins have borne this out*—."

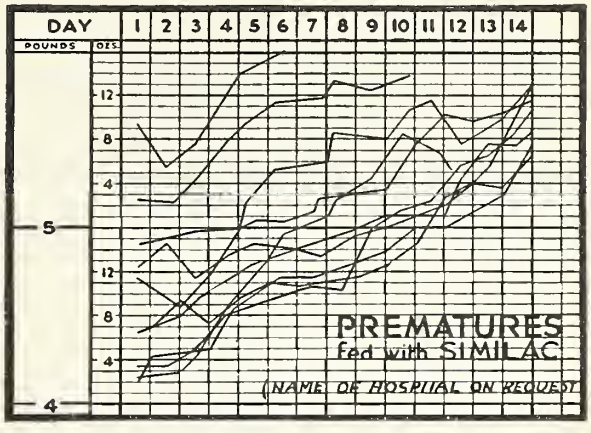
The observations referred to covered only three prematures fed on different fats, but showed an average of 78.4% retention for olive oil as compared to only 52.5% retention for butter fat.

*Holt, Tidwell and Kirk, Studies on Fat Metabolism in Infants—Acta Pediatrica. Vol. XVI, 1933.

SIMILAC

has given noticeably good results in feeding the premature infant. One of the reasons lies, as here pointed out, in the composition of its fat. Another reason is its consistently zero curd tension. The finer the curd the greater the surface area. The greater the surface area the more exposed are the fats, carbohydrates, proteins and salts to the digestive enzymes. Result . . . the food substances are more quickly and readily utilized.

SIMILAC is made from fresh skim milk (casein modified) with added lactose, salts, milk fat, and vegetable and cod liver oils.



ACCEPTED AMERICAN MEDICAL ASSN.

The fact that SIMILAC is well assimilated by the immature digestive tract of the premature indicates how entirely suitable it is for all those infants who are deprived of breast milk.

M & R DIETETIC LABORATORIES, Inc., Columbus, Ohio

culosis Sanatorium, Cincinnati.

X-Ray Examination of Uterus and Fallopian Tubes—by Dr. E. C. Steinharter, Jewish Hospital, Cincinnati.

Pulmonary Tumors—by Dr. Samuel Brown, Tumor Clinic, Jewish Hospital, Cincinnati.

Urological Diseases—by Dr. E. O. Swartz and Dr. H. B. Freiberg, Cincinnati.

Evolution and Decline of Human Dentition—Dr. Samuel Rabkin, Cincinnati.

Nephroptosis—by Dr. Parke G. Smith and Dr. Gordon McKim, Cincinnati.

Cardio-Vascular Studies in Pregnant Women—by Dr. J. E. Benjamin, Dr. Harry Landt and Dr. John Oldham, Cincinnati.

Eye Pathology—by Holmes Hospital, Cincinnati.

Hare Lip and Cleft Palate—by Dr. Reed Shank, Cincinnati.

Carcinoma of Rectum, Combined Abdominal Perineal Resection—by Dr. T. E. Jones, Cleveland Clinic.

Tumors of the Kidney—by Dr. W. E. Lower and Dr. B. H. Nichols, Cleveland Clinic.

Tuberculosis Program of Cincinnati Health Department—by Cincinnati Department of Health.

Climatic and Weather Effects on Man—by Dr. C. A. Mills, Cincinnati.

Cancer of Breast, Uterus, Skin and Face—by American Society for Control of Cancer, New York.

Tumor Clinic of Cincinnati General Hospital—by Dr. Wm. Millar, Cincinnati.

Chemistry and Histology of Atherosclerosis—by Dr. Pearl M. Zeek, Cincinnati General Hospital.

Studies on Lead—by Kettering Laboratory, University of Cincinnati.

Microphotography—by Dr. Carl Hiller, Cincinnati.

Anemias of Childhood—by Dr. George Guest.

Research Institute, Children's Hospital—by Glenn Cullen, Cincinnati.

Treatment of Some Fractures as Carried Out at Cincinnati General Hospital—by Dr. John A. Caldwell, Cincinnati.

Demonstrations of Pathological Preparations, Bacterial Cultures, Serum Reactions and Sugar Tolerance Tests—by Drs. Oscar Berghausen and Alfred O'Neil, Bethesda Hospital, Cincinnati.

Heart and Aorta—by Dr. Samuel Brown, Jewish Hospital, Cincinnati.

A Study of the Common Bile Duct and Biliary Tree after Operation—by Dr. Fred M. Douglass, Toledo.

Rapid Pneumococcus Typing by the Neufeld Reaction—by Department of Medicine, University of Cincinnati.

Exhibit of Art—by Department of Surgery, Division of Art, University of Cincinnati.

Natural Color Photomicrographs of Blood Films Stained by Wright's Method—by Dr. Russel L. Haden, Cleveland Clinic.

Annual Health Commissioners' Conference, November 13-15

Sixteenth Annual Conference of Ohio Health Commissioners with the State Department of Health will be held in Columbus at the Deshler-Wallick Hotel, November 13, 14 and 15.

The first session will be held on Wednesday afternoon, November 13, starting at 2:30, and will be officially opened with an address of welcome by Governor Martin L. Davey. This will be followed by an address by Dr. R. R. Hendershott, Tiffin, president of the Ohio State Medical Association, and the annual address of the State Director of Health, Dr. Walter H. Hartung.

The Thursday morning, November 14, session will open at 9:00 A.M., with Dr. N. C. Dysart, health commissioner of Columbus, presiding. The following addresses will be presented:

"Public Health Nursing", Miss Pearl McIver, Associate Public Health Nursing Analyst, U. S. Public Health Service; "What a Health Commissioner Can Do With Vital Statistics", Dr. John Collinson, Assistant Statistician, Vital Statistics, U. S. Bureau of Census; "Ohio Government Survey—Abstract on the Department of Health", Dr. J. A. Doull, professor of hygiene and public health, Western Reserve University, Cleveland; "Maternal and Child Health", Dr. Martha Eliot, Assistant Chief, Children's Bureau, U. S. Department of Labor; 'Observations on Scarlet Fever", Dr. W. G. Rhoten, health commissioner of Wooster and Wayne County.

A public health luncheon will be held at noon. "Who's Who", a dialogue on diphtheria prevention, will be presented by Dr. A. L. Van Horn, chief of the Bureau of Child Hygiene, State Department of Health, and Dr. P. L. Harris, medical inspector, Division of Communicable Diseases, State Department of Health.

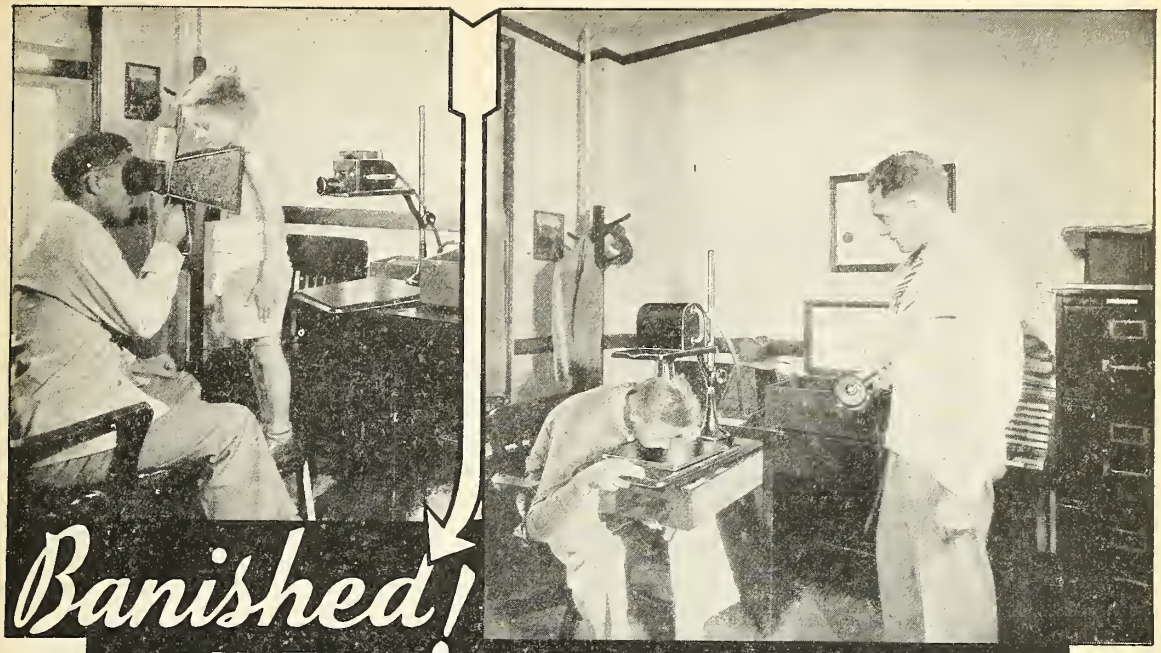
The Thursday afternoon session will be presided over by Dr. R. H. Markwith, health commissioner of Summit County. The following addresses will be presented:

"Tuberculosis", by Dr. J. A. Myers, professor of preventive medicine and public health, University of Minnesota Medical School, Minneapolis, Minnesota; "Certain Developments in Health and Sanitation in the Tennessee Valley", Dr. E. L. Bishop, chief medical officer of the Tennessee Valley Authority.

A business session of the Ohio Federation of Public Health Officials will conclude the conference.

—OSMJ—

The Rockefeller Foundation has granted $10,000 to the School of Applied Sciences, Western Reserve University, to be used "to strengthen the public health nursing practicing field for graduate and undergraduate nursing students".



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DEATHS IN OHIO

Conrade Alleyne Howell, M.D., Columbus; Cleveland University of Medicine and Surgery, 1888; Ohio Medical University, Columbus, 1901; aged 69; Fellow of the American College of Surgeons; former member of the Ohio State Medical Association and the American Medical Association; died September 21, from pneumonia. In 1889 Dr. Howell was appointed surgeon at the Ohio Penitentiary by Governor Foraker. Shortly thereafter he entered private practice in Columbus, continuing there until his retirement in 1934. During the World War, Dr. Howell served as a captain in the Medical Corps of the U. S. Army, and was chief surgeon of the U. S. Base Hospital at Fort Sam Huston, Texas. He was the author of several books and magazine articles, including "Surgical Nursing and Hospital Technique", and an extensive three-volume work on abdominal surgery. He was a member of the Episcopalian Church, Masonic and Elks lodges and American Legion. Surviving are his widow, two brothers, and four sisters.

Harry Alexander Lindsay, M.D., Sidney; State University of Iowa, College of Medicine, Iowa City, 1906; member of the Ohio State Medical Association and the American Medical Association; aged 63; died Sept. 18, from a self-inflicted wound. Dr. Lindsay, who had been in ill health, practiced in Iowa and in Kansas City before locating in Sidney in 1925. During the World War he was captain in the Medical Corps of the U. S. Army, stationed at Camp Dodge, Iowa. Dr. Lindsay was prominent in civic affairs in Sidney and served as president of the Shelby County Medical Society for two years. He was a member of the First Presbyterian Church and the Masonic order. His widow survives.

William D. Porter, M.D., Cincinnati; Medical College of Ohio, Cincinnati, 1887; aged 74; member of the Ohio State Medical Association and Fellow of the American Medical Association; professor-emeritus of Clinical Obstetrics, College of Medicine, University of Cincinnati; member of the American Society of Obstetricians and Gynecologists; died September 27, from heart disease. Dr. Porter practiced in Cincinnati for nearly 50 years. He was on the staff of the Bethesda, Jewish and General Hospitals, taught in the medical school and did considerable writing on obstetrical subjects. He served one term as president of the Cincinnati Academy of Medicine. He is survived by his widow, a son and two daughters.

Charles Thaddeus Souther, M.D., Cincinnati; Medical College of Ohio, Cincinnati, 1902; aged 59; member of the Ohio State Medical Association and Fellow of the American Medical Association; member of the Western Surgical Association and Fellow of the American College of Surgeons; died October 12, following a heart attack. He is survived by his widow and a brother.

William H. Matchett, M.D., Greenville; University of Michigan Medical School, Ann Arbor, 1899; aged 59; former member of the Ohio State Medical Association and the American Medical Association; died October 3, following an extended illness. Surviving are his widow and a son.

Arthur D. Spence, M.D., South Lebanon; Miami Medical College, Cincinnati, 1895; aged 67; member of the Ohio State Medical Association and the American Medical Association; died October 4, following a month's illness. Dr. Spence practiced in South Lebanon for 40 years. He was a member of Methodist church, and the Masonic, Odd Fellows, and K. of P. lodges. He is survived by his widow, two daughters and a son.

J. Richardson Smith, M.D., Cleveland; Medical College of Ohio, Cincinnati, 1907; aged 57; died September 21, following a short illness. Dr. Smith was a native of Georgia. He had practiced in Cleveland for twenty years. Surviving are his widow and a daughter.

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COUNTY SOCIETIES *and* ACADEMIES

First District

Butler County Medical Society met at Middletown Hospital, September 18. Dr. Malcolm Bronson gave observations of his recent tour of Europe.—News Clipping.

Clermont County Medical Society held its regular meeting Wednesday, September 26, at New Richmond. Dr. Frank Swing, Cincinnati, spoke on "Middle Ear Disease and Its Implications". Dr. Robert B. Cofield, Cincinnati, addressed the meeting on "Orthopedic Conditions of Interest to the Obstetrician", and Dr. E. I. Davies, Cincinnati, discussed the subject.—News Clipping.

Fayette County Medical Society met at the Cherry Hotel, Washingon C. H., Thursday afternoon, September 12. Dr. D. J. Kindel, Cincinnati, was the speaker.—News Clipping.

Hamilton County—The Academy of Medicine of Cincinnati presented the following programs during October:

October 8—"Deficiency Diseases of Adults: General Considerations", by Dr. M. A. Blankenhorn. Discussion by Dr. T. D. Spies, "Recent Developments in the Treatment of Pellagra".

October 15—"Some Aspects of the Pathological Physiology of Cerebrospinal Fluid", by Dr. D. B. Remsen, Baltimore, Md. Discussion by Dr. H. D. McIntyre, "Infective Neuronitis".

October 22—"American Medical Association", (Moving Pictures) by Dr. A. A. Hayden, Chicago, Illinois.

October 29—Case Reports. "Dermatitis Venenata Caused by a Beetle Belonging to the Family of the Sacred Scarabs of Ancient Egypt", by Dr. Karl Zwick. "Acute Suppurative Petrositis, Diagnosis, Operation and Recovery", by Dr. Henry M. Goodyear. "Typhoid Pyelo-Nephritis", by Dr. Charles J. McDevitt. "A Newly Discovered Cause of Asthma", by Dr. Joseph B. Biederman.—Bulletin.

Highland County Medical Society was addressed by Dr. V. S. Counsellor, Mayo Clinic, Rochester, Minnesota, on the subject "Diseases of the Pelvis", at a meeting held October 11 at the Parker Hotel, Hillsboro.—News Clipping.

Second District

Darke County Medical Society met at Greenville, Friday evening, September 20. Dr. Martin H. Fischer, Cincinnati, discussed "Medicine and Our Future".—News Clipping.

Greene County Medical Society held its regular monthly meeting at Xenia on October 11. A report of the state meeting was given, and several subjects of local interest were discussed. Dr. E. M. Huston, Dayton, President-elect of the State Association, talked informally on "Medical Organization". Dr. L. W. Sontag, director of Fels Research, gave an interesting resume of the research work in progress there.—Reyburn McClellan, M.D., Secretary.

Miami County Medical Society met at Memorial Hospital, Piqua, October 11. Obstetrical care was the subject for discussion. Dr. W. W. Trostel, Piqua, spoke on "Ante Partum Care", following which motion pictures on obstetrics were shown. Dr. E. R. Irvin, Bradford, concluded the meeting with a talk on "Post Partum Care".—G. A. Woodhouse, M.D., Secretary.

Montgomery County Medical Society met at the Fidelity Medical Building, Dayton, September 27. Dr. R. G. Leland, Director of the Bureau of Medical Economics of the American Medical Association, addressed the society on "The Responsibility of the Medical Profession".

The October meeting of the society was held at the New Hospital, National Military Home, Dayton, October 18. The following program was presented by members of the staff:

"Nutritional Anemia Severe", Dr. J. A. Baird; "Blastomycosis of Left Lung without Cutaneous Lesion", Dr. E. B. Miller; "Osteomalacia, Severe (Decalcification and Distegration of the Skeletel System) with Severe Anemia", Dr. S. C. Woldenberg; "Aseptic Necrosis of the Hip Joint, Bilateral", Dr. C. C. Burton; "Aneurysm of Sinus of Valsalva with Slight Aortic Insufficiency", Dr. L. M. Hohman; "Residual Empyema with Complete Thoracoplasty and Subsequent Anterior Costectomy", Dr. S. Galinson.—Bulletin.

Preble County Medical Society met at Seven Mile Tavern, Eaton, Thursday, October 17. Dr. Warren Briedenbach, Dayton, was the speaker.—C. E. McKinley, M.D., Secretary.

Third District

Hardin County Medical Society held a joint meeting with the dentists of the county September 19, at the Kenton Cafe. C. C. Sherwood, D.D.S., Toledo, spoke on "Oral Infection and its Relation to Systemic Diseases". J. D. Sullivan, D.D.S., and E. N. Bach, D.D.S., Toledo, also spoke. —Calvin G. Jackson, M.D., Secretary.

Marion County—Marion Academy of Medicine met at the City Hospital, Marion, October 9. Dr. S. W. Mattox gave a talk, illustrated with moving pictures, on the Pan-American Cruise. Dr. Frederick G. Smith discussed the subject of "Amoebiasis", and Dr. Martin M. Weinbaum spoke on "Malaria: Tertian Form".—News Clipping.

Seneca County Medical Society held its annual dinner meeting at Lake Mohawk, Tiffin, Thursday,

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September 12, with approximately 50 members, their wives and guests from adjoining counties attending.—News Clipping.

Fourth District

Lucas County—The Toledo Academy of Medicine held a general meeting at the Academy Building, Friday evening, October 4. Dr. Grover C. Penberthy, Detroit, president of the Michigan State Medical Society, discussed "Tannic Acid Treatment of Burns", with lantern slides and motion picture demonstration.

The following section meetings were held during October:

October 11—Section of Pathology, Experimental Medicine and Bacteriology. Dr. S. M. Goldhammer, Ann Arbor, Mich., spoke on "The Physiology and Treatment of Macrocytic Anemias".

October 18—Medical Section. Dr. William H. Meffley told of his observations on clinics and private medical practice in Europe. "Observations on Obstetrical and Gynecological Clinics at Johns Hopkins Hospital, Baltimore, Md.", was the subject of an address by Dr. J. M. McWilliam.

October 25—Surgical Section. Dr. E. C. Mohr discussed "Spinal Anesthesia and Hysterectomy". —Bulletin.

Sandusky County Medical Society met at the City Hall, Fremont, Thursday, September 25. The problem of providing medical care for indigents locally was discussed. Dr. Dean E. Sheldon, Sandusky, read a paper on "Management of the Occipito-posterior Position".—Carl J. Wolf, M.D., Secretary.

Wood County Medical Society met at the Bowling Green General Hospital, September 19. Dr. Larry Clark, Toledo, spoke on "Childhood Tuberculosis".—R. N. Whitehead, M.D., Secretary.

Fifth District

Cuyahoga County—The Academy of Medicine of Cleveland presented the following programs during October:

October 7—Clinical and Pathological Section at Charity Hospital. "Vascular Diseases of the Extremities", by Drs. E. P. Neary and C. G. Barber; "Appendicitis with Peritonitis—Resume of Methods", by Dr. F. C. Herrick; "Radical Antrum Operation through the Hard Palate", by Dr. Wm. G. Mussun; "Cauterization of Vocal Cords for Bilateral Paralysis", by Dr. S. H. Large; "Pericardial Effusion following Stab Wound of Chest", by Dr. I. H. Einsel.

October 9—Section on the Practice of Medicine at Herrick Room. "Some Impressions on Diagnosis and Treatment from a Vascular Disease Clinic", by Dr. Herman Shube. Discussion, "Negative Pressure", by Dr. John Bright; "Temperature Reaction", by Dr. Howard C. Eddy; "Histamine Reaction", by Dr. A. Carlton Ern-

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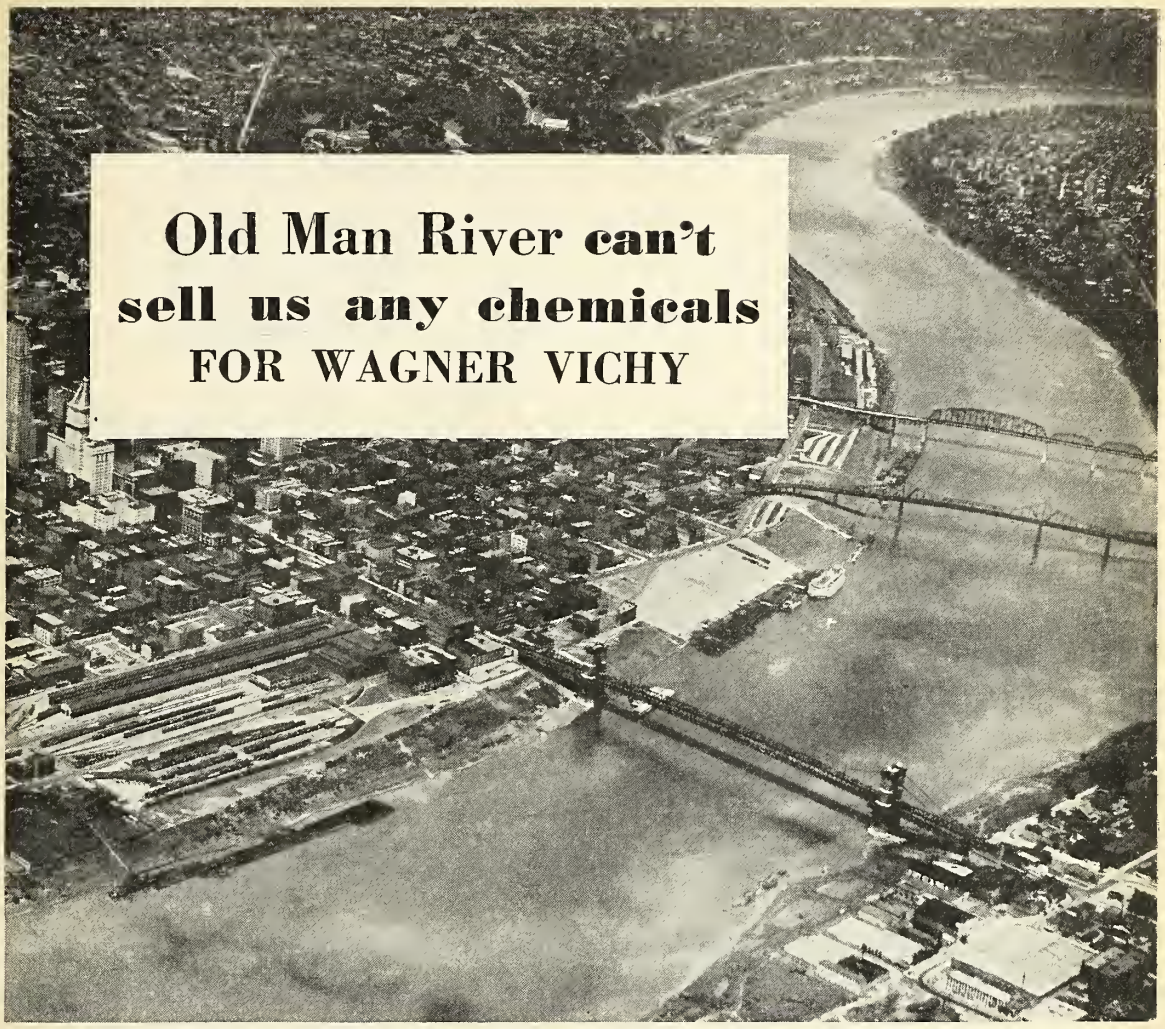
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stene; "Oscillometry", by Dr. F. A. LeFevre. "Accelerating Factors in Chronic Degenerative Arthritis", by Dr. W. A. Warren.

October 11—Joint Meeting of the Experimental Medicine Section and Cleveland Section of the Society for Experimental Biology and Medicine, at Institute of Pathology. "Malaria in Aurora, Ohio", by R. N. Hoyt, Dr. P. H.; "Lipolytic Action of Streptcocci", by Dr. E. Megrail and E. C. Weclesser; "A Comparison of the Results of the Kline and Kahn Tests", by Eleanor Taylor and E. R. Miller; "The Significance of Small Amounts of Diphtheria Antitoxin in the Blood Serum", by Dr. R. C. Hahn; Oxidation-reduction Potentials and Bacterial Growth", by R. L. Thompson, D.Sc. "Experimental Pertussis in the Chimpanzee: with Phonographic Demonstration", by Dr. G. S. Shibley, "Active Immunization against Pertussis: preliminary report of field study", by Drs. J. A. Doull, G. S. Shibley, J. E. McClelland and R. C. Hahn.

October 16—Obstetrical and Gynecological Section, Herrick Room. Program presented by members of the Staff of Tumor Clinic, Cleveland City Hospital, "Treatment of Pelvic Tumors in Women". Introduction by Dr. Howard T. Karsner. "Clinical Application of Tumor Grading", by Dr. Herbert S. Reichle; "Carcinoma of the Ovary", surgical treatment—by Dr. Donald M. Glover, *X*-ray treatment by Dr. Harry Hauser. "Carcinoma Fundus Uteri", Surgical Treatment by Dr. S. O. Freelander, *X*-ray and Radium Treatment by Dr. Alwyn E. Bennett; "Carcinoma Cervix Uteri"—Radium Treatment (motion picture) by Dr. Lawrence A. Pomeroy, *X*-ray Treatment by Dr. Harry Hauser. The subject was summarized by Dr. Lawrence A. Pomeroy and the discussion opened by Dr. William H. Weir.

Industrial Medicine and Orthopedic Section, St. Luke's Hospital. "Fractures—Presentation of Cases", by Dr. James V. Seids; "Plastic Surgery and Burns", by Drs. Donald M. Glover and Arnold F. Sydow; "Orthopedic Surgery—Presentation of Cases", by Dr. Theodore A. Willis; "Traumatic Neuroses", by Drs. A. D. Nichol and Richard E. Stout.

October 25—Opthalmological and Oto-Laryngological Section, Medical Library Auditorium. Symposium on Brain Abscesses with Pathways of Infection, Leading to Meningeal Complications. "Pathways from the Ear", Dr. O. J. Walker, Youngstown; "Pathways from the Orbit", Dr. G. L. Miller; "Pathways from the Nose and Throat", Dr. C. W. Engler; "Brain Abscess, the Management and Prognosis", Dr. Wm. J. Gardner.—Bulletin.

Geauga County Medical Society meeting at Burton, September 25, formulated a protest against extending the sales tax to include professional services, to be sent to State Representative Ward. "Socialized Medicine", was the subject of a general discussion.—Isa Teed-Cramton, M.D., Secretary.

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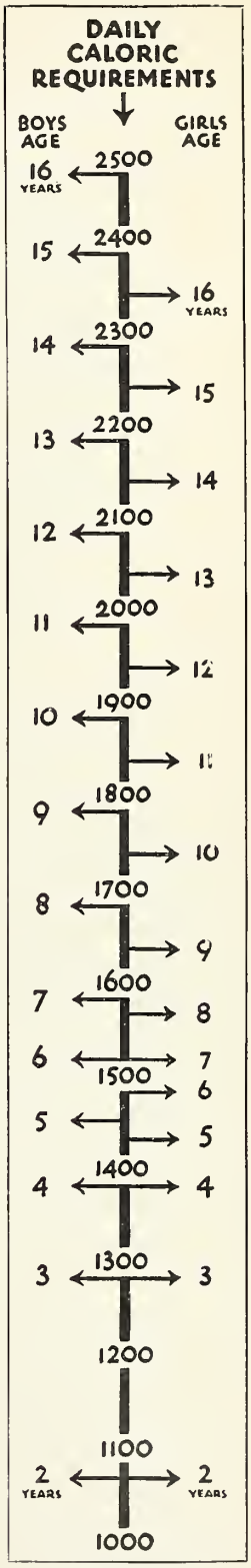
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Huron County Medical Society met at Municipal Hospital, Sandusky, September 18. Dr. N. W. Gillette, Toledo, discussed, "Abdominal Surgery in Children".—News Clipping.

Lorain County Medical Society held its first Fall meeting at Lorain, October 9. Dr. Howard T. Karsner, Cleveland, discussed "Pathology of Bright's Disease".—Z. Pitcher, M.D., Secretary.

Medina County Medical Society held its annual picnic at Mac's Dam, LeRoy, September 15. Families of the members and a number of guests from Cleveland and Akron also were present.—News Clipping.

Sixth District

Ashland County Medical Society enjoyed a fishing party and picnic supper at Long Lake, September 11. Dr. M. J. Thomas, Jeromesville, was chairman of the committee on arrangements.—News Clipping.

Mahoning County Medical Society was addressed by Dr. Chas. Gordon Heyd, Professor of Surgery, Columbia University on the subject "The Role Occupied by the Liver in Abdominal Surgery", at its regular monthly meeting, Tuesday, October 15, at the Youngstown Club.—Bulletin.

Portage County Medical Society met at Robinson Memorial Hospital, Ravenna, Thursday, October 10. The program consisted of reports by delegates to the Annual Meeting of the State Association, and a paper on "Epilepsy", by Dr. John H. Nichols, Cleveland. E. J. Widdecombe, M.D., Secretary.

Stark County Medical Society held its regular monthly meeting at The Elk's Club, Canton, Monday, October 7. The speakers were Dr. Floyd Hendrickson, Canton, who discussed "Vesical Neck Obstruction in the Female", and Dr. George Wenger, Massillon, who talked on "Lumbar and Sacral Anaesthesia in Perineal Surgery".—H. W. Beck, M.D., Secretary.

Summit County Medical Society met at the Mayflower Hotel, Akron, Tuesday, October 1. Dr. Frederick J. Kalteyer, Clinical Professor of Medicine, Jefferson Medical College, spoke on "Observations on Abdominal Pain".—Bulletin.

Seventh District

Columbiana County Medical Society held a meeting September 10 at the American Legion Hall, Lisbon. Dr. Charles N. Bailey, East Liverpool, spoke on "Acute Surgical Conditions of the Abdomen".—News Clipping.

Tuscarawas County Medical Society met at the home of Dr. R. J. Foster, New Philadelphia, president of the Society, September 12. Plans were discussed for rendering medical care to indigents. Dr. William Hudson, Dover, addressed the meeting on "Incipient Tuberculosis".—News Clipping.

Eighth District

Athens County Medical Society held a meeting September 9 at the home of Dr. T. A. Copeland,

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Athens. The speaker was Dr. S. Aaron Price, clinical professor of pathology and director of the New York Polyclinic Hospital and Medical School, former resident of Athens.—News Clipping.

Muskingum County Academy of Medicine met in conjunction with the Muskingum County Bar Association and the Dental Society of the Muskingum Valley, Tuesday evening, October 15, at the Hotel Rogge, Zanesville. Dr. Homer Brown, D.D.S., Columbus, discussed "The Trends and Philosophies of Social-Economic Readjustment". —Beatrice T. Hagen, M.D., Secretary.

Perry County Medical Society held a meeting at the Park Hotel, New Lexington, September 16. Dr. R. A. Ramsey, Columbus, spoke on "Some Practical Aspects in the Management of Thyroid Diseases".—News Clipping.

Ninth District

Hocking County Medical Society held its regular meeting October 10 at The Ambrose Hotel, Logan. Dr. Roy Krigbaum, Columbus, addressed the society on "The Temple Treatment for Eclampsia and the Latest Work on Obstetric Analgesia, Hemorrhage and Infection".—M. H. Cherrington, M.D., Secretary.

Scioto County—The regular meeting of the Hempstead Academy of Medicine was held at Portsmouth, Monday evening, October 14. Dr. C. D. Fife, Dayton, discussed "Some Practical Considerations of the Cardio, Renal, Vascular Case". —William E. Scaggs, M.D., Secretary.

Tenth District

Franklin County—Columbus Academy of Medicine presented the following programs during October:

October 7—"A History of Resuscitation", by Dr. Drew L. Davies, who gave a demonstration of resuscitation and the use of the H. & H. inhalator, with the cooperation of Squad No. 1, Columbus Fire Department.

October 14—"The Treatment of Gonorrhea in the Male", by Dr. Louis J. Roth; "The Treatment of Gonorrhea in the Female", by Dr. Phillip J. Reel; "Gonorrheal Arthritis", by Dr. Edward Harlan Wilson.

October 21—"Intercostal Nerve Blocking in the Treatment of Pulmonary Diseases", by Dr. Donald E. Yochem, with discussion by Dr. C. H. Benson and Dr. George M. Curtis.

October 28—General Practitioners' Section. "The Treatment of Syphilis in General Practice", by Dr. Ralph E. Ramey; "Syphilis as a Public Health Problem", by Dr. C. M. Valentine.

Morrow County Medical Socicty held a meeting at the Globe Hotel, Mt. Gilead, Tuesday, October 8, with dentists of the county as guests. Dr. E. G. Horton, Columbus, spoke on "The Common Errors of Pediatrics".—T. Caris, M.D., Secretary.

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NO NEW TAXES IN 1936 ARE NEEDED, LATEST REPORT ON OHIO'S FINANCES REVEALS

AS a result of a series of conferences on the Ohio fiscal and taxation situation, participated in by representatives of the Ohio State Medical Association and numerous other professional, business and industrial organizations, a fact-finding committee has been engaged in a thorough survey and study to determine the revenue needs of the state and whether or not existing tax laws would produce adequate funds to meet the obligations of the state government for 1936.

This well-qualified committee has obtained data from various official sources, and after a thorough investigation has formulated its report.

The report has been presented to the Governor and the members of the Ohio General Assembly for their information and guidance during the taxation session of the legislature in November.

Based on a balance sheet which showed that the state and local subdivisions will be able through existing laws to meet their absolute needs, although in a few instances local governments may have to augment their income by voting tax levies to finance purely local governmental functions, the committee has concluded that *no new taxes are necessary to finance Ohio's obligations in 1936.*

The committee has recommended the re-enactment of the retail sales tax, expiring December 31, 1935; the liquid fuel tax, expiring December 31, 1935, the cigarette tax, expiring October 31, 1936 and the 1 per cent temporary increase in the tax rate on productive investments.

The report states that with the re-enactment of these taxes, it will be possible for the state and local government to finance their obligations in 1936.

It also presented the following tables to show that the budget can be balanced *without the enactment of new taxes:*

OBLIGATIONS

1.	Aid for the Aged	$12,000,000
2.	Direct relief for unemployables	16,000,000
3.	School foundation program	50,562,000
4.	Retirement of outstanding relief bonds	8,000,000
5.	Retirement of Carey Relief Bonds to be issued	2,500,000
6.	Aid to local governments	10,553,000
	Total	$99,615,000

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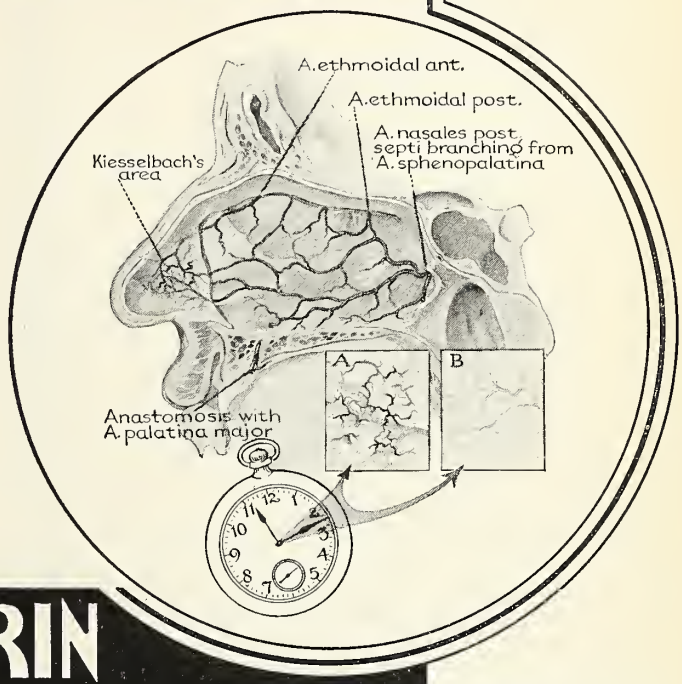
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1.	Sales Tax	$55,000,000
2.	Liquid Fuel	10,500,000
3.	State Intangibles Tax	5,500,000
4.	Cigarette Tax (re-enactment, for last 2 months 1936)	850,000
5.	First Public Utility Poor Relief Excise Tax (1%)	2,200,000
6.	Second Public Utility Excise Tax (1%) (Carey Act Poor Relief Bonds)	2,500,000
7.	Admissions (3%)	1,200,000
8.	Malt and Wort	70,000
9.	Beverage Tax	1,150,000
10.	Surplus in County Poor Relief Excise Tax Fund	500,000
11.	Carey Act Bonds Available for 1936 Relief	8,000,000
12.	Liquor Monopoly Profit	6,000,000
13.	Wine Tax	2,000,000
14.	Barrel Beer Tax	3,000,000
15.	Spirituous Liquor Tax	3,500,000
	Total	$101,970,000

The above tables show that the total unfinanced obligations for 1936 amount to $99,615,000, whereas the anticipated net resources, without the enactment of new taxes, amount to $101,970,000, leaving $2,355,000 as a surplus of resources.

The committee in its report stated that all estimates of revenues are conservative, and that the surplus might actually exceed the amount indicated, particularly if the economies recommended by the Sherrill Ohio Government Survey are adopted.

—OSMJ—

Post-Graduate Study Program at Akron on November 7

The Third Post-Graduate Study Program of the Summit County Medical Society will be presented at the Mayflower Hotel, Akron, Thursday, November 7.

The speakers will be Dr. W. W. Babcock, professor of surgery and clinical surgery, Temple University; Dr. J. A. Kolmer, professor of medicine, Temple University, and Dr. Temple Fay, professor of neurological surgery, Temple University.

The following program will be presented:

At 2:00 P.M.—"Malignant Disease of the Intestine"—Dr. Babcock; "Important Considerations in the Administration of Fluids"—Dr. Fay; "Vaccination Against Infantile Paralysis"—Dr. Kolmer.

Dinner will be served promptly at six.

At 7:00 P.M.—"Common Errors in Surgical Practice", Dr. Babcock; "Cerebral Injuries and Management of Intracranial Pressure Problems", by Dr. Fay; "Some Principles and Practical Applications of Chemo-therapy", by Dr. Kolmer.

A registration fee of $5.00 will be charged. This includes the dinner.

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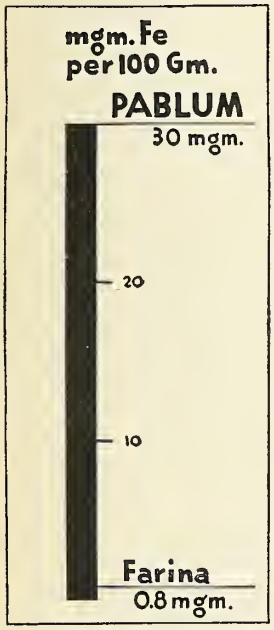
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The high vitamin B content of Pablum assumes new importance in light of recent laboratory studies showing that avitaminosis B predisposes to certain gastro-intestinal disorders. Apropos of this, Cowgill says, "Gastric ulcer is another disorder which can conceivably be related to vitamin B deficiency. Insofar as the treatment of this condition usually involves a marked restriction of diet the occurrence of at least a moderate shortage of this vitamin is by no means unlikely. Obviously the length of the period of dietary restriction is an important determining factor. Dalldorf and Kellogg (1931) observed in rats subsisting on carefully controlled diets that the incidence of gastric ulcer was greatly increased in vitamin B deficiency. Observations of this type merit serious consideration."[3] Sure and Thatcher (1933) produced ulcers in rats, similar to those in human gastric ulcer, as a result of specific vitamin B deficiency.[4] Clinical observations by Dickson,[5] Elsom,[6] Larimore,[7] and Mackie[8] lead them to believe that diets low in vitamin B may be conducive to gastro-intestinal disorders, including ulcerative colitis.

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The OHIO STATE MEDICAL JOURNAL

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DECEMBER 1, 1935 VOL. XXXI Number 12

December Features . . . . .

Symposium—Progress in Tuberculosis

Clinical Aspects of Alkalosis

Conservatism in Gynecology

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Proceedings of the December meeting of The Council, including preliminary arrangements for the 1936 Annual Meeting at Cleveland.

"Do You Know—", first of a series of thumb-nail sketches about the services offered all members of the State Headquarters Office at Columbus.

JANUARY 1st IS THE DEADLINE FOR 1936 MEMBERSHIP DUES. HAVE YOU PAID YOURS?

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The Ohio State Medical Journal

Vol. XXXI DECEMBER, 1935 No. 12

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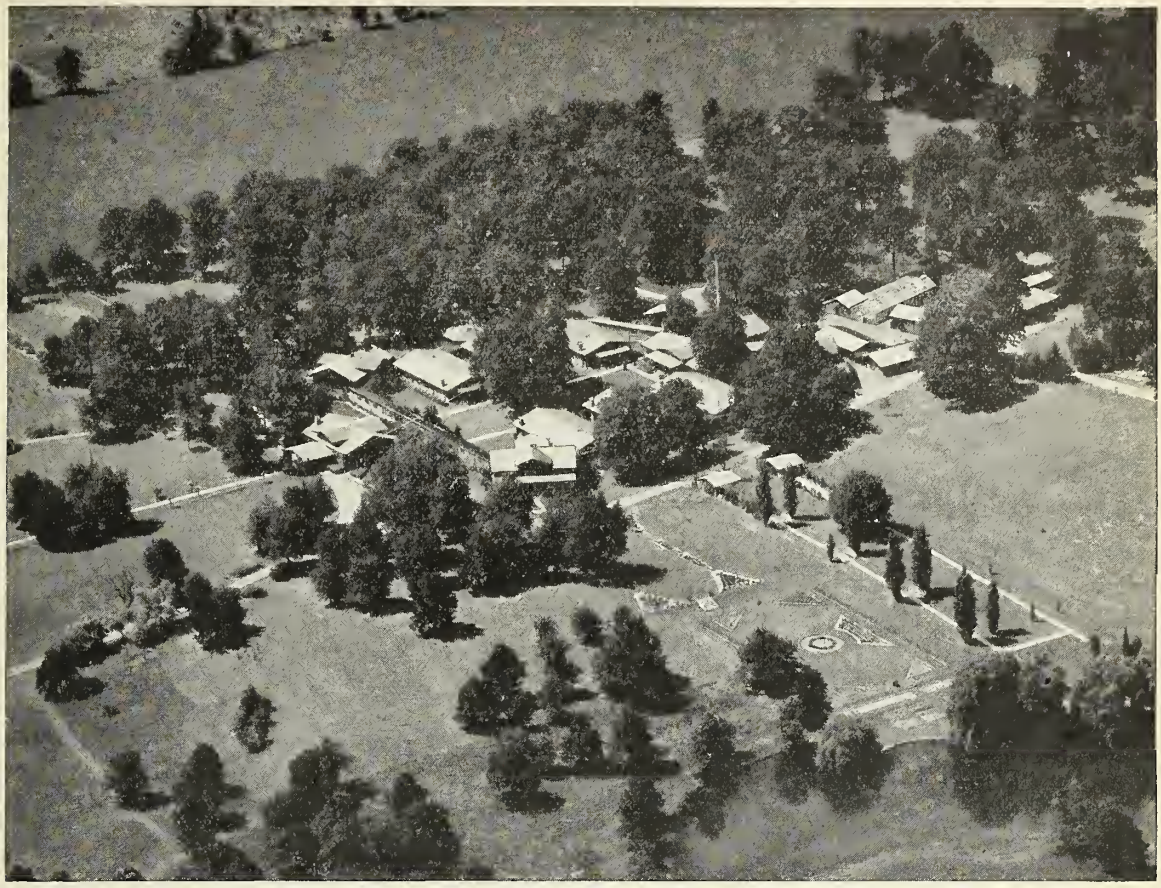
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Allen	W. A. Noble, Lima	H. C. Weisenberger, Lima	3d Tuesday, monthly.
Auglaize	E. F. Heffner, Wapakoneta	C. C. Berlin, Wapakoneta	2nd Thrusday, bi-monthly.
Hancock	H. O. Crosby, Findlay	R. S. Rilling, Findlay	1st Thrusday, monthly.
Hardin	F. M. Elliott, Ada	W. N. Mundy, Forest	3d Thursday, monthly.
Logan	C. K. Startzman, Bellefontaine	M. L. Pratt, Bellefontaine	1st Friday, monthly.
Marion	J. A. Dodd, Marion	F. D. Yeager, Marion	1st Tuesday, monthly.
Mercer	L. M. Otis, Celina	F. E. Ayers, Celina	2d Thursday, monthly.
Seneca	W. W. Lucas, Tiffin	R. E. Hershberger, Tiffin	3d Thursday, monthly.
Van Wert	B. L. Good, Van Wert	C. A. Morgan, Van Wert	1st Tuesday, monthly.
Wyandot	B. A. Maloney, Upper Sandusky	L. W. Naus, Upper Sandusky	1st Thursday, monthly.
Fourth District			
Defiance	P. B. Newcomb, Defiance	H. B. Wideman, Defiance	2nd Tuesday, Sept. to June
Fulton	C. F. Hartmann, Wauseon	Geo. McGuffin, Pettisville	3d Thursday, monthly.
Henry	C. G. Hissong, Hamler	F. M. Harrison, (dec'd) Napoleon	2nd Tuesday, monthly.
Lucas	T. L. Ramsey, Toledo	F. C. Clifford, Toledo	Friday, each week.
Ottawa	L. L. Belt Marblehead	Cyrus R. Wood, Port Clinton	2nd Thursday, monthly.
Paulding	K. C. Evans, Payne	F. A. McCammon, Payne	3d Wednesday, monthly.
Putnam	C. W. Bird, Continental	L. M. Piatt, Ottawa	1st Tuesday, monthly.
Sandusky	A. F. Schultz, Fremont	C. J. Wolf, Fremont	Last Thursday, monthly.
Williams	E. R. Jacka, Bryan	H. R. Mayberry, Bryan	2nd Thursday, monthly, Sept. to June.
Wood	F. L. Sterling, Bowling Green	R. N. Whitehead, Bowling Green	3d Thursday, monthly.
Fifth District			
Ashtabula	E. H. Merrell, Geneva	M. R. Martin, Geneva	2nd Tuesday, monthly.
Cuyahoga	Lester Taylor, Cleveland	J. A. Garvin, Cleveland	3d Fri., Feb., March, May, Sept., Nov., Dec.
Erie	L. S. Hill, Sandusky	R. M. Knoble, Sandusky	Last Thursday, monthly, except July, Aug.
Geauga	F. S. Basquin, Chardon	Isa Teed-Cramton, Burton	Last Wednesday, Apr. to Dec.
Huron	L. H. Hayhurst, Greenwich	C. B. Thomas, Greenwich	Once monthly, Feb., May, Sept. and Dec.
Lake	C. H. Browning, Painesville	Mabel Pearce, Painesville	Last Tuesday, monthly.
Lorain	L. H. Trufant, Oberlin	Zina Pitcher, Elyria	2nd Tuesday, monthly.
Medina	F. C. Reuter, Spencer	J. K. Durling, Wadsworth	3d Thursday, monthly.
Trumbull	M. T. Knappenberger, Warren	A. H. Seiple, Warren	2d Tues., monthly, Sept.-May.

Societies	President	Secretary	
Sixth District	R. S. Friedley, Akron	K. H. Harrington, Akron	2d Wed., Jan., April and Oct.
Ashland	L. G. Sheets, Ashland	M. J. Thomas, Jeromesville	2d Friday, Sept. to May
Holmes	Clyde Bahler, Walnut Creek	C. T. Bahler, Walnut Creek	1st Wed., Feb., Apr., June, Aug., Oct., Dec.
Mahoning	J. L. Fisher, Youngstown	W. M. Skipp, Youngstown	3d Tuesday, monthly.
Portage	A. M. Landsborough, Garrettsville	E. J. Widdecombe, Kent	1st Thursday, monthly.
Richland	B. E. Shreffler, Mansfield	H. C. Winbigler, Mansfield	Last Thursday, monthly.
Stark	M. E. Scott, Massillon	H. W. Beck, Canton	2d Tues., monthly, except July and Aug.
Summit	J. D. Smith, Akron	A. S. McCormick, Akron	1st Tuesday, monthly.
Wayne	W. A. Fritz, Wooster	R. C. Paul, Wooster	4th Friday, monthly.
Seventh District			
Belmont	W. L. Davis, Martins Ferry	C. W. Kirkland, Bellaire	1st Thurs., monthly, 4 p. m., except July and August.
Carroll	(With Stark Co. Society)		
Columbiana	F. R. Crowgey, Salem	G. E. Byers, Salem	2d Tuesday, monthly.
Coshocton	C. M. Neldon, Coshocton	J. D. Lower, Coshocton	4th Thurs., monthly.
Harrison	A. C. Grove, Jewett	W. C. Wallace, Hopedale	3d Wednesday, monthly.
Jefferson	W. H. Minor, Steubenville	J. Y. Bevan, Steubenville	3d Tuesday, monthly.
Monroe	G. W. Steward, Woodsfield (dec'd)	A. R. Burkhart, Woodsfield	2d Wednesday, monthly.
Tuscarawas	R. J. Foster, New Philadelphia	C. M. Dougherty, New Phila.	2d Thursday, monthly.
Eighth District			
Athens	W. E. Howe, Nelsonville	T. A. Copeland, Athens	1st Monday, monthly.
Fairfield	K. W. Taylor, Pickerington	C. W. Brown, Lancaster	2d Tuesday, monthly.
Guernsey	C. A. Craig, Cambridge	Reo Swan, Cambridge	1st and 3d Thursday each month.
Licking	Geraldine Crocker, Granville	G. A. Gressle, Newark	Last Friday, monthly.
Morgan	D. G. Ralston, McConnelsville	C. E. Northrup, McConnelsville	3d Tuesday, monthly.
Muskingum	W. D. Coffman, Zanesville	Beatrice C. Hagen, Zanesville	1st Wednesday, monthly.
Noble			
Perry	C. B. McDougal, New Lexington	F. J. Crosbie, New Lexington	3d Monday, monthly.
Washington	A. H. Smith, Marietta	R. M. Meredith, Marietta	2d Wednesday, monthly.
Ninth District			
Gallia	E. G. Lupton, Gallipolis	Milo Wilson, Gallipolis	1st Wed., Feb., May, Sept. and Dec.
Hocking	J. L. Webb, Nelsonville	M. H. Cherrington, Logan	2d Thursday, monthly.
Jackson	J. S. Hunter, Jackson	J. J. McClung, Jackson	2d Tuesday, monthly.
Lawrence	R. F. Massie, Ironton	W. W. Lynd, Ironton	1st Thursday, monthly.
Meigs	H. M. Crumley, Pomeroy	R. E. Boice, Middleport	3d Thursday, bi-monthly.
Pike	L. E. Wills, Waverly	R. T. Leever, Waverly	1st Monday, monthly.
Scioto	R. P. Elder, Portsmouth	Wm. E. Scaggs, Portsmouth	2d Monday, monthly.
Vinton	O. S. Cox, McArthur	H. D. Chamberlain, McArthur	3d Wednesday, monthly.
Tenth District			
Crawford	M. L. Helfrich, Galion	C. J. Griebling, Galion	1st Monday, monthly.
Delaware	J. K. James, Delaware	W. E. Borden, Delaware	1st Tuesday, monthly.
Franklin	E. G. Horton, Columbus	Drew Davies, Columbus	1st four Mondays, monthly.
Knox	E. V. Ackerman, Fredericktown	R. L. Eastman, Mt. Vernon	Last Thursday, monthly.
Madison	R. W. E. Irwin, Mt. Sterling	F. A. Lutz, Mt. Sterling	4th Wednesday, monthly.
Morrow	E. C. Sherman, Cardington	T. Caris, Mt. Gilead	Last Thursday, monthly.
Pickaway	R. S. Hosler, Ashville	E. R. Austin, Circleville	1st Friday, monthly.
Ross	O. P. Tatman, Chillicothe	W. C. Breth, Chillicothe	1st Thursday, monthly.
Union	P. D. Longbrake, Marysville	H. E. Stricker, Marysville	2d Tuesday, monthly.

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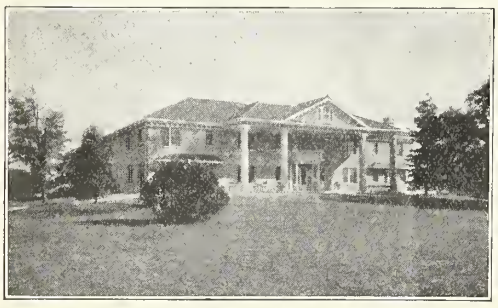
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SYMPOSIUM—PROGRESS IN TUBERCULOSIS *

By CHARLES A. DOAN, M.D., BRUCE K. WISEMAN, M.D., and GEORGE M. CURTIS, M.D., COLUMBUS, OHIO

PREVENTION, BACTERIOLOGY, IMMUNOLOGY, CHEMISTRY AND PATHOLOGY

By Charles A. Doan, M.D.

IN coming to you this morning to survey briefly in this symposium the accomplishments, as well as to recognize frankly the unsolved problems of tuberculosis, as it exists today, we wish to emphasize first of all the importance of *prevention* as still the most satisfactory modern answer to this age-old question. The hope of preventing disease is one of the earliest of medical aspirations. Nevertheless, it was only a hundred years ago that Laennec defined the objectives of the medical profession without mentioning the idea of prevention. "The aim of medicine," said this eminent physician, "is the *cure* of disease."

The century that has elapsed since this pronouncement has seen an unprecedented advance in the undertsanding of disease processes. This new knowledge has led to an increase in the facilities for the control of disease, and to achievements in its actual prevention, that capture the imagination. These accomplishments have been followed, naturally enough, by a gradual change in the practice of medicine and by a change in the point of view of the physician and the lay public, until Sir George Newman can write today: "The ideal of medicine is the *prevention of disease*, and the necessity for curative treatment is a tacit admission of its failure."

To point out, thus, the differences in these two concepts of the functions of medicine may suggest that there is some incompatibility between the two objectives,—prevention and cure. Nothing, of course, could be farther from the truth. Preventive measures and curative activities are both directed at common enemies—disability and premature death.

Among the causes of permanent or long continued disability and death, tuberculosis remains far too prominent, particularly among adolescents and young adults. The discovery of the tubercle bacillus by Koch in 1882 seemed at first to promise a speedy solution to the riddle of "the great white plague". Koch was the first to show that tuberculosis was not due, as men had supposed, to "bad" heredity or to weakened constitutions, but to the growth of a special type of microscopic organism, an acid-fast bacillus, which may be spread by contact from man to man, or from animal to man. With this key discovery, viz., that infectious diseases are spread by the dissemination of invisible living agents—a means at last of *preventing* many of the former scourges of mankind,—cholera, typhoid fever, bubonic plague, dysentery, diphtheria, et al.,—was realized. Modern sanitation and modern public health with all of their attendant blessings have been a direct outgrowth of the discoveries in bacteriology originating late in the 19th century with Koch and Pasteur.

From the Department of Medical and Surgical Research The College of Medicine, Ohio State University.

Presented before the Fourth General Session of the Ohio State Medical Association, at the 88th Annual Meeting, Columbus, Ohio, October 5, 1934.

Unfortunately, however, tuberculosis has not yielded so quickly and so completely to the immunological studies of the past fifty years as certain of the other infectious diseases. Due to differences inherent in the tubercle bacillus and its relationship to its host, the simpler laws of immunity have not been applicable. Yet of all the infectious diseases tuberculosis should be the most susceptible of control, because (1) of the relative natural immunity of the majority of humankind to a minimal infecting dose of organisms; (2) the disease when established rarely leads to an "open" lesion or cavity capable of disseminating the infecting agent; and (3) unless susceptible individuals are more or less continuously in direct contact with such an "open" case the chances for the development of the clinical disease are remote. With this information established and well authenticated the rationale for, and the ultimate success of, an intelligent program for the detection and isolation of active, open cases in any and every community is clear.

Granting unequivocally then the preferable control and eradication of tuberculous disease through preventive measures, we, nevertheless, now have, and will continue indefinitely to have, the problem of the treatment of those individuals unfortunate enough to contract the disease despite present knowledge. The responsibility here is twofold; the rehabilitation economically of the patient through arrestment of his disease; and the protection of society against each such potential focus of dissemination. Despite the complexity of the disease once it has become established, each decade since Koch's epochal discovery, has seen an appreciable increase in our knowledge of the underlying factors, which modify and condition the clinical and pathologic manifestations of tuberculosis, and a steadily decreasing morbidity and mortality rate continue to reflect, at least in some measure, the successful clinical application of these slowly accumulating principles.

The decade immediately past has been no exception to this general rule. A critical analysis of this period reveals at least four outstanding major contributions, whose influence upon the understanding and control of tuberculous disease will probably persist and prove of increasing importance and significance so long as tuberculosis remains a problem for the human race: (1) the application of the phenomenon of bacterial dissociation to the acid fast group of organisms, primarily through the ingenious modifications of technic developed in Petroff's laboratory at Trudeau, has established once and for all the biologic instability and virulence variability of so-called pure strains of tubercle bacilli; (2) the sharper differentiation of the cell types in the blood and their relationship to the cells in the tissues,—more particularly the identification of the monocyte of the blood with the epithelioid cell of the tissue tubercle,—has laid the foundation for new pathologic concepts of the disease and has provided the basis for hematologic studies and prognostic interpretations hitherto unrecognized; (3) the extensive chemical analyses of the acid-fast group of bacilli carefully grown in adequate quantities on a synthetic medium have revealed new molecular structures with specific biologic properties, which bear directly upon the mechanism underlying the protean clinical manifestations of tuberculous disease; and (4) the introduction of surgical measures in the management of intractable tuberculous disease, where the best medical skill has proved inadequate in the rehabilitation of the individual, gives new hope for "arrestment" to a very considerable portion of our present day sanatoria population.

The individuals in our group have been personally identified more or less intimately during the past decade with both the laboratory and the clinical researches above mentioned upon which current progress in the diagnosis and treatment of tuberculosis is based, and it is our purpose this morning to outline briefly for you the more significant theoretical and practical aspects of the problem, some appreciation of which is essential to the intelligent handling today of the individual tuberculous patient.

Any consideration of tuberculosis must start with as comprehensive an understanding of the causative agent, the acid fast bacillus of Koch, as it is possible to achieve. Cultures of acid fast organisms in the past represented confluent, granular, chromogenic or non-chromogenic growths slowly developing and devoid of individual colony structure, whether planted on fluid or on solid media. With the perfection of a new technic for seeding plates with a dilute suspension of individual acid fast bacilli, which includes sealing to prevent dehydration of the medium during the long incubation period[1], a method by which individual colonies might be examined and studied was obtained for the first time.

It became apparent at once that a remarkable variation in colony topography and physical and pigmentary characteristics existed in supposedly pure strains of long isolated and frequently studied cultures. Some colonies were smooth, moist and moth ball-like, and when introduced into salt solution or fluid media at once dispersed wtihout trituration into an homogeneous suspension. Various rougher modifications of this smooth colony appeared coincidently on the same plate, until, at the other extreme a dry, rough, serrated, frequently highly chromogenic colony, resistant to dispersion in suspension was encountered. As might be anticipated under such circumstances, carefully controlled virulence studies showed striking contrasts as measured by the longevity of experimental animals and the type and extent of pathologic lesion, between these topographi-

cally different colonies composed of differing pleomorphic forms of acid fast organisms.

By animal passage[2,3] and by varying the composition and especially the pH of the synthetic media used in culturing the organisms, these divergent "R" and "S" forms have been influenced predominantly toward the one or the other extreme. Morton Kahn[4] using the single cell isolation technic has taken single organisms from both "R" and "S" colonies and from the subsequent colony of bacilli arising from a single pregenitor again recovered by dissociation both types of colonies. Furthermore, the sharp division of acid fast organisms into bovine, avian and human types on the basis of pathogenicity for experimental animals may no longer be strictly used as a basis for classification. So many exceptions have been cited in recent years and so many strains of pathogenic acid fast bacilli isolated, which do not conform to the classic criteria, that in this group of organisms as in the streptococci we must accept the greatest biologic variability as fundamental to and characteristic of the group.

This growing conception of the acid fast bacilli as adaptive to changing environment, and as possessing various degrees of pathogenicity under varying conditions, cannot but influence the present day appraisal of Calmette's proposal for the use of an attenuated living tubercle bacillus of bovine origin as a vaccine against human tuberculous disease. In the experimental laboratory no culture of any organism has ever yet been found to remain perfectly stable under all circumstances. The interaction of environment upon the hereditary constitution, each modifying the other to produce an unpredictable end product, is a universal biologic law. The long latent period which may elapse between initial invasion and terminal exacerbation in tuberculous infections is well-known both from experimental and from clinical data.

The importance of dust factors in certain industries in activating latent pulmonary tuberculosis has only recently been appreciated (pneumoconiosis, anthracosis, silicosis). The relative benignity and tendency to spontaneous healing of a primary focus of tuberculous disease is as well established now as is the serious nature of clinical activity in the so-called adult type of secondary exacerbation, so that the question has been raised as to the efficacy of a primary infection as a protection against ultimate progressive tuberculous disease. Boynton[5] in surveying the tuberculosis problem in Minnesota has found that the mortality rates in children are lower and have decreased at a more rapid rate under a program of prevention and control than is reported from Gothenburg, Sweden, where extensive application of the B.C.G. vaccine has been made. Between 1915 and 1932—seventeen years—the mortality from tuberculosis declined 72 per cent for all children under fifteen years of age, 88 per cent for infants under one year, and 58 per cent for the general population in the state, without any form of vaccination,—a truly remarkable record.

In brief, all of the recent increase in our knowledge of the biologic characteristics of the tubercle bacillus, and much of the experimental and clinical data concerning immunity to tuberculous disease, suggest conservatism in the adoption of any vaccination principle which involves the introduction of a living acid fast virus into the human body.

The *second* marked advance of the last ten year period in the study of tuberculous disease has to do with diagnosis and prognosis. With the advent of the *X*-ray the identification and character of pulmonary lesions and our knowledge of the evolution of tuberculous disease of the respiratory tract was immeasurably facilitated. More recently it has been found that careful studies of the blood will reveal, earlier perhaps than any other sign or symptom, impending changes in the state of activity of tuberculous disease. The monocyte-lymphocyte ratio, the qualitative character of the lymphocytes and monocytes, and the degree of hemoglobin anemia reflect, respectively, the proliferative, the cellular defense and the toxic or mineral deficiency manifestations of the disease as will be elaborated by Dr. Wiseman in the second paper of this symposium. Such studies also provide a means of accurately and promptly assaying the efficacy of any given therapeutic regime outlined for the treatment of the active disease. At the present time no examination for suspected clinical tuberculosis is complete without these special blood studies, and no therapeutic regimen may be so promptly and accurately appraised without them.

The *third* major contribution of the past decade to the knowledge of tuberculosis has to do with additional information regarding the chemical constitution of the tubercle bacillus, and the biologic significance of these chemical factors. Under the patronage and leadership of the Research Committee of the National Tuberculosis Association a cooperative investigation has been undertaken, which enlisted the services of scientific investigators in some seven universities and three research institutes, and included the resources of two large pharmaceutical firms.

It had long been known that lipoids made up a very considerable portion of the acid fast organism, and the chemical studies of Anderson[7] at Yale University have furnished fractions for biologic testing[8] which form the basis for believing that the epithelioid and Langhans giant cells, which comprise the tubercle, the chief pathologic unit of the disease, represent the specific reaction of the tissues to tuberculo-phosphatide, when this foreign material is not otherwise disposed of and eliminated by the body[9]. New fatty

acids have been isolated which underlie the proliferative phases of the disease.

The polysaccharides[10] seem to influence strikingly the temperature fluctuations and the granulocytic leucocytoses of the body when they are found.

The most important practical application of these chemicobiologic studies to date has to do with the proteins. In any individual who harbors the living tubercle bacillus there develops an altered tissue reaction, which may be demonstrated by injecting a small quantity of the material upon which the bacilli have been grown, into the skin of the arm. This reaction was first described by Robert Koch and the material used he designated "tuberculin." Due to variations in the strains of organisms used, and to differences in the composition of the media employed, "old tuberculin" has varied in the past in potency as widely as the sources from which it has been supplied. No basis for comparison in either diagnostic or therapeutic studies has, therefore, existed. Chiefly through the studies of Seibert[11], the skin reacting specificity of the tubercle bacillus has been demonstrated to reside in a Purified Protein Derivative of a molecular weight approximating 2000 to 4000, which classifies the molecule among the proteoses or possibly polypeptides. Grown on synthetic medium of known composition, three human strains of tubercle bacilli long used in the Bureau of Animal Industry under Dr. Dorset's supervision as a basis for the tuberculin prepared for cattle testing throughout this country, now provide the source of PPD for human tuberculin testing. Seibert has demonstrated that the strain of bacilli used within the same type does not alter the potency of the final purified product, but the yield does vary markedly with the organism used. It is highly significant that as the size of the tuberculin protein molecule is decreased there is noted an accompanying loss in antigenicity, until in the case of the PPD product now available for clinical use, practically the entire power for eliciting the Arthus phenomenon, for producing precipitins, or of precipitating highly immune serum is lost without diminution in skin reacting properties.

By an ingenious method of combining this active principle with beta lactose, .0002 mgm. and .05 mgm. respectively of the Purified Protein Derivative are dispensed in ¼ grain weight sterile tablets. A diluting fluid of buffered saline is supplied for preparing the testing solution just prior to use.

It has been determined through an exhaustive series of clinical tests that .00002 mgm. PPD is equivalent to .002 to .01 mgm. Koch's Old Tuberculin (depending on source) and is a safe dosage for an initial tuberculin skin test. If the first test is negative, a second test using .005 mgm. PPD (equivalent to 1 mgm. O.T.) may be used. A positive skin reaction does not mean active disease. When present, it does indicate further study to determine whether danger to self and to others exists. The importance of the epidemiologic spread of tuberculosis in this country is obvious. The tuberculin skin test is the best single method of establishing the incidence of infection in any given community. Inasmuch as direct contact is the major method of spread of tuberculosis, it is essential for prophylaxis to know where the disease exists, and to isolate those actively diseased for their own good, and for the health of family and friends, oftentimes unknowingly and unnecessarily exposed to infection.

The unqualified endorsement of the National Tuberculosis Association and the integrity of the research workers involved, assures the standardization of the new product, and extensive enough use has already been made throughout many selected groups and communities to establish the specificity and future usefulness of PPD. Thus, another contribution of the decade to the understanding and control of tuberculosis may be attributed to the intelligent, cooperative investigations of chemist and biologist in a way and to an extent not hitherto observed. More important, however, than any concrete accomplishment to date, is the promise of a continuing stream of new knowledge from these sources, which we may anticipate in future applications to our problem.

The *fourth* major contribution of the present era to tuberculosis has to do with the development of new methods of direct treatment in moderately and far advanced cases of the disease. The introduction of surgical measures in the management of intractable tuberculous infection, where the best medical skill has proved inadequate in the rehabilitation of the individual, gives new hope for the arrestment of the disease in a very considerable proportion of our present day sanatoria population. Operative procedures directed toward placing the infected part at rest more completely than simple bed rest can accomplish, have changed the course of events in an increasingly large number of sick patients. A careful selection of patients and discrimination in the operative procedure of choice, are, of course, essential. The best modern medical and surgical management of each individual, as an individual, is necessary to assure optimum results. But granting these requisites, new possibilities in the surgical treatment of tuberculosis have been developed, which, once the disease has become established, will alter its course more successfully than any measures hitherto devised. Our group during the past two years has had the opportunity of observing, and from personal experience can now attest to, the value of surgery in the treatment of tuberculosis, as Dr. Curtis will indicate in the final presentation in this symposium. Surgery of the lung is a development of very recent years, but when car-

ried out in competent hands and in properly selected patients, the results more than justify the risks involved. In these patients, as in those under medical management, we have found the information obtained through careful blood studies to furnish the most sensitive and reliable indices available, in the selection and management of individual cases. (For details see second and third papers in this symposium).

The College of Medicine of the Ohio State University has been actively represented in the development as well as in the application of these several advances along the front in the fight on tuberculosis. As has been stated, the modern fight against disease must compass every resource, and in tuberculosis this uniting of forces from many institutions scattered across the country has resulted in real progress. The diagnosis and the treatment of tuberculosis, as in every chronic disease, must be accomplished as early as possible, if successful recovery is to follow. Nature can heal the lesions of tuberculosis in the majority of individuals. With a little more knowledge, and particularly with a better application of the information already available, the necessary requisite to health may be extended to the unfortunate victims of progressive disease. But, as was emphasized in the beginning, the real reduction in the mortality rate can only follow an ever increasing reduction in the incidence or morbidity of the disease.

In any discussion of tuberculosis today, one must be reminded of the two best known daughters of Asklepios, the father of Medicine. These daughters were called, respectively, Hygeia and Panacea, and they went about doing good, the one by prevention, the other by cure. The fact of their sisterhood in early mythology illustrates the close relationship which must continue to exist between preventive and curative medicine. With both preventive measures and therapeutic procedures increasingly effectively applied, by an enlightened profession to an understanding and cooperative citizenry, tuberculosis in the next decade should show a greater decrease in incidence and death rate than in any preceding decade in world history.

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II. HEMATOLOGY

By Bruce K. Wiseman, M.D.

ALTHOUGH the discovery by Koch of the tubercle bacillus made possible the application of Virchow's principles of cellular pathology to the study of tuberculosis more than 50 years ago, it has not been until comparatively recently that this problem has been explored in its finer details. True, the chief concern of the intervening years centered in the consolidation of the position of medicine as a whole upon the scientific basis establishd by the brilliant investigations of Claude Bernard, Cohnheim, Pasteur, Lister, Helmholtz, Hoppe-Seyler, Schmiedeberg, Ludwig, His, and others of that period rather than in advancing its outposts. But more than this, important progress in the better understanding of the pathology of tuberculosis has been dependent upon the recognition of a new principle of solving difficult scientific problems—the principle of cooperative research.

Recognizing the relatively static position to which research in tuberculosis had devolved, the National Tuberculosis Association in 1923 appointed a committee to initiate and coordinate cooperative research, compassing eventually personnel in seven univeristies, two pharmaceutical houses and the Rockefeller Institute for Medical Research, and representing the highest skill in the fields of bacteriology, biological chemistry, pathology and immunology. It is scarcely too much to say that progress in the better understanding of the finer pathologic reactions, as well as their clinical application to tuberculosis has been greater in the last ten years than in the forty preceding, an attainment due in large part to the successful working of this cooperative principle.

Since cellular pathology is the foundation stone of hematology it was inevitable that progress in these specialties should be coincidental. "Blood counts" had been done for years in cases of tuberculosis, but rarely did they reveal anything of importance. In the experimental studies, the elucidation and correlation of the cellular changes in the tissues with those of the blood, suggested that interpretations which had not been stressed in the past were possible, and that with improved techniques and an adequate understanding of the cellular reactions of the tissues of the host, much valuable information could be determined in the clinical disease. Therefore, today, in the light of

the progress of the past eight years, blood "counts" are no longer adequate in tuberculosis; but blood *examinations*, by skilled hematologists capable of interpreting their findings, have assumed a new order of importance and the observations so obtained are exceedingly valuable to the modern clinician even as are those obtained with the *X*-ray, the stethoscope and other methods of examination.

THE CELLULAR REACTION IN TUBERCULOSIS

As emphasized in the foregoing paragraphs, a thorough understanding of the cellular reactions occurring in the tissues when brought into contact with the tubercle bacillus, or with the chemical substances emanating from its metabolism in the body is of the greatest importance in any consideration of the hematologic aspects of the disease[1,2]. The blood stream is to be regarded as a transport system, the cells in which reflect the transformations that are occurring in the tissues of the body. These transformations are of two origins; first, the local reaction to the bacilli, and second, the lesions which have been induced in the more distant tissues by dissemination of the soluble products (endotoxins) of the bacillus. The changes in the blood cells, themselves, are of two kinds; first, alterations in the quantitative relationships; and second, and of even greater importance, changes in their qualitative characteristics. It is emphasized that the interpretation of the blood picture in a given case of tuberculosis at any given time depends upon the skill with which these various changes in the blood cells are recognized and interpreted in terms of the underlying tissue changes.

Chart 1 illustrates in diagramatic form, the cellular reactions of the tissues to the tubercle bacillus and its products, together with the qualitative and quantitative changes in the blood-cells which result directly or indirectly therefrom. The tubercle bacillus is represented in this chart as containing three active chemical substances, namely, protein, carbohydrate, and fats, as well as various inactive substances, water, minerals, etc. The liberation of the active substances has a powerful effect upon the tissues represented by the three rectangles shown in the center of the diagram, which in turn is reflected in the blood. The significance of these changes as they relate to the formation of tuberculous granulation tissue and tubercles is represented by the rectangle at the lowermost portion of the diagram. The direction of the lines connecting the various figures indicate the sequence of these changes and their derivation from a particular bacterial substance.

The dissemination of tuberculo-protein is responsible for the major portion of the toxemia of the disease and thereby exerts a non-specific influence upon lymph nodes and bone marrow. The liberation of small amounts of protein produces a stimulatory effect on lymphatic structures, resulting in an increase in the peripheral level of lymphocytes. This response is apparently favorable to the healing of the tubercle and possibly also helps in controlling the toxemia of the disease. Larger concentrations of the tuberculo-protein are destructive to lymphatic proliferation with the result that the lymph follicles show varying degrees of chromatolysis; a lymphopenia results with a degenerative "shift to the left" in the lymphocytic elements.

The tuberculo-protein interferes principally with the synthesis of hemoglobin and the maturation of granulocytes in bone marrow. Very high concentrations also affect adversely the actual production of red cells (not shown on the chart) but this is usually effectively balanced by the stimulatory effects of the anoxemia resulting from tubercle formation in the lungs; in fact a relative polycythemia is occasionally encountered as the end result of the imbalance of these opposing forces.

The adverse effect upon the maturation of neutrophilic granulocytes is revealed as a shift to the left in the Arneth pattern. This constitutes one of the more delicate indications for the detection of sub-clinical degrees of activity. From these facts it is clear that the proper appraisal of the qualitative and quantitative characteristics of the lymphocyte reveal important information as to the progress of healing and detoxification taking place in the body. The significance of this observation to prognosis has recently been pointed out elsewhere[3] and will be emphasized again. It is also clear that a proper evaluation of the extent of the left-shift in granulocytes is important in analyzing the degree of activity of the tuberculous lesion.

The dissemination of the carbohydrate fraction of the tubercle bacillus is responsible, at least in part, for the mobilization of the neutrophilic granulocytes since it can be easily proved experimentally that this substance has powerful chemotactic properties. The bacterial products of other organisms (non-specific secondary invaders) undoubtedly are also chemotactic for these cells. In any case a maintained high peripheral level of granulocytes is indicative of impending caseation, cavitation and pus production and thus points to the importance of considering some form of collapse therapy.

The dissemination of tuberculo-phosphatid (more specifically the active fatty acid, tuberculinic acid) stimulates specifically the monocytes in the connective tissues, thus inducing the formation of added quantities of these cells and at the same time promoting the metamorphosis of these units into epithelioid cells. The presence of increased numbers of monocytes and/or of monocytes in partial state of transformation into

of hemoglobin and a progressive anemia is always to be regarded as a very ominous sign in tuberculosis. The fall in red cells in the latter months is interpreted as resulting probably in part from the damaging effects of the tuberculo-protein but mostly from infection secondary to this wasting disease.

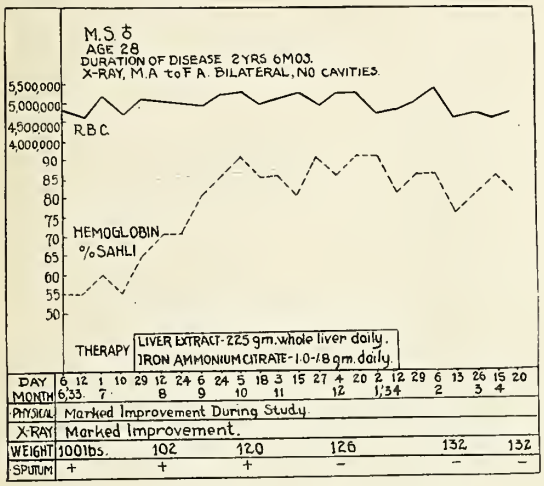


Chart 4. Progressive changes in the red blood cells and hemoglobin in a patient in which therapeutic attempts to correct the anemia were partially successful. The hemoglobin is shown in percent (Sahli). The lower one-fourth of the chart shows the clinical progress of the patient during the study.

Chart 4 shows the progressive changes in the red blood cells and hemoglobin in a patient in which therapeutic attempts to correct the anemia were in part successful. This patient, a white female, age 28 years, had likewise suffered from tuberculosis for two and a half years. Upon admission to the Licking County Sanatorium the *X*-ray diagnosis was M. A.—A. and the hemoglobin was at a very low value (5.5 gms. per 100 cc. of blood, Newcomer). After two months of the usual sanatorium care the condition had not improved. The patient was then put upon Whipple's secondary anemia fraction of liver plus iron and ammonium citrate in the dosages indicated on the chart with immediate improvement both clinically and hematologically as shown. The hemoglobin could not, however, be raised higher than 9 grams per cu. mm. of blood with these measures.

The interpretation of the findings in this particular patient is that there were two factors that were contributing to the anemia; first, interference with the synthesis of hemoglobin because of the toxemia of the disease, and second, a state of exhausted or very low reserve of iron and other substances necessary for the structure of the hemoglobin molecule. The therapeutic measures instituted corrected the part of the anemia due to the deficiency factors, but of course did not influence that which was due to the primary disease itself. This case illustrates the importance of analyzing the significance of an anemia, when present, both from the standpoint of using the hemoglobin value as an aid in interpretation of the progress of the disease as well as meeting a therapeutic indication when it arises. No argument should be necessary to establish the fact that a satisfactory hemoglobin value is a favorable factor in the fight against tuberculosis, in that additional rest to the lung is secured by obviating the necessity for increased pulmonary ventilation in order to supply adequate oxygen to the tissues.

(b) *Cases illustrating the significance of changes in the white blood cells.*

In evaluating the changes in the white blood cells the question of technique assumes some importance. In determining the proportional relationships of the different types as well as for a survey of the qualitative alterations in individual cells, more particularly the monocytes, the supravital method is without question of great value. To obtain mathematical expressions of the Arneth index and Wiseman's "shift in the lymphocytes", fixed preparations stained with one of the Romanowsky methods (May-Grünwald, Jenner-Giemsa or Wright's-Giemsa) has certain advantage over the supravital method. The latter fixed staining techniques also provide a permanent record. Only the maximum of essential data can be obtained when both techniques are used and the observations from each correlated. Quite satisfactory information may be secured, however, by use of the stained preparations only, such for example as Wright's-Giemsa method of fixation and staining. Whatever method is used, the success of the observation lies in obtaining blood films that are not only sufficiently thin to study the individual cells, but also perfectly stained. An adequately trained individual can make reliable observations upon satisfactory preparations, whereas the most highly skilled hematologist can obtain very little from poor preparations.

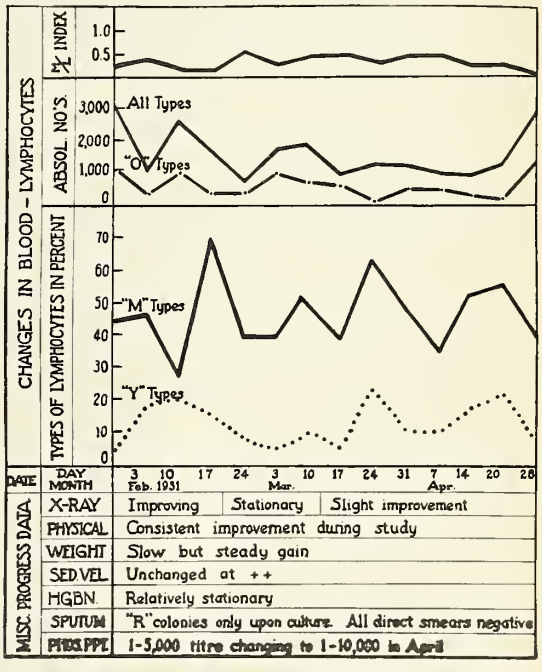


Chart 5. Progressive qualitative changes in the lymphocytes of patient R. N. This chart correlates the clinical and sundry laboratory observations (lower one-third) with the fluctuations in the lymphocytes in correct time sequence.

Chart 5* shows the course of events in a pa-

* Data represented by Charts 5 and 6 were obtained upon patients in residence at the Franklin County Sanitarium at Columbus, Ohio. Acknowledgment is made for the very valuable assistance given by Dr. M. D. Miller, Superintendent of that institution, who aided in the collection of the data and is responsible for the observations relating to the sedimentation velocity of the red blood cells.

tient with pulmonary tuberculosis drawn to emphasize the changes in the lymphocytes (upper 2/3 of the chart) as these were correlated with other data (bottom 1/3 of the chart).

The patient, R. N., a white female age 26, had had pulmonary tuberculosis for six years prior to admission to the sanatorium. For seven months antedating the blood studies here recorded, she had received the routine institutional care. At the time of these observations (Chart 5), the clinical and laboratory examinations revealed only minimal activity, although the *X*-ray diagnosis was interpreted as M. A.—A. An examination of the curves on this chart shows three things that are of especial importance: first, the M/L index is consistently below 0.5 which indicates that epithelioid proliferation is not progressing; second, the total number of lymphocytes is for the most part less than the critical level of 2,000 per cu. mm. of blood, which, when interpreted without a consideration of the qualitative changes in these cells would indicate a failure of adequate healing; and third, an analysis of the curve representing the young ("Y") lymphocytes shows that while the values are above the upper limits of normal (thus substantiating the clinical findings of activity), yet these cells are neither continuously nor markedly elevated.

There are three periods during which the young forms reach 20 per cent of the total, namely, Feb. 10, March 24, and April 20. These may be said to represent transient periods of regeneration and reflect periods in which an increased demand for lymphocytes is evident. It will be observed that during the first period increased regenerative activity raised the total level of lymphocytes to approximately 3,000 per cu. mm. of blood, probably because no increase in destruction or turnover of these cells (indicated by a relatively stationary "O" curve) occurred coincident with the increase in their production.

During the second period (Mar. 24) of increased regeneration, the peripheral level of lymphocytes did not rise, due to the rate of peripheral destruction which had now risen to balance the new influx of cells. The success of this increased turnover of lymphocytes is shown by the sustained regenerative activity which culminated in a third peak, with rising "O" curve the peripheral level of total lymphocytes rising again to the 3,000 mark. The significance of this phenomenon lies in its accurate reflection of the ebb and flow of activity of the tuberculous process. An analysis of these qualitative changes is particularly important when the relative level of the total lymphocytes is low. This chart clearly demonstrates one of the fundamental facts of modern hematology; namely, that any accurate interpreation of the cellular reaction in the blood may be achieved only through a study of their qualitative characteristics in addition to their quantitative variations.

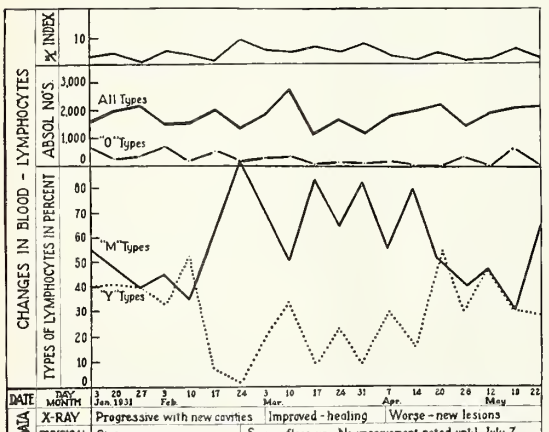


Chart 6. Progressive qualitative changes in the lymphocytes of patient W. I. This chart correlates the clinical and sundry laboratory observations (lower one-third of the chart) with the fluctuations of the lymphocytes in relative time sequence.

A further illustration of the added information that a thorough analysis of the lymphocytes may furnish in a given case of tuberculosis is illustrated in Chart 6. This represents the blood findings from W. I., a white male of 22 years of age with pulmonary tuberculosis of three years' standing. The *X*-ray examination on Jan. 3, 1931, showed a lesion classified as F. A.—C and the clinical study showed marked evidences of activity. A study of the lymphocyte curves shows that during the first month lymphocyte regeneration was at a very high point, 40 per cent of the lymphocytes being of the young variety. On Feb. 24, a paralysis of the regenerative activity occurred followed one week later by the first evidence of a clinical flareup. Lymphocytic regeneration was resumed, however, on March 3, and proceeded in ever increasing volume until April 20 at which time the young types were again being maintained at a high level. This favorable lymphocytic balance anticipated the first signs of clinical improvement in this patient by about three months.

For a detailed discussion of the theoretical implications of this chart, reference is made to a former publication[3]. The point to be made here is that the analysis of the changes in the lymphocytes not only reflected the course of events in the patient more accurately than most of the other observations made, but actually anticipated the clinical episodes by a substantial interval. The potential error in any limitation of the considerations to quantitative data only, is also quite clear since at no time did the total numbers of lymphocytes reflect the changing gravity of the situation. In this particular case the observations that paralelled each other and the clinical course most accurately were the M/L index, the phosphatide precipitin test[13, 14], the predominating "R" or "S" type of organism recovered upon culture from the sputum, and the qualitative changes in the lymphocytes.

Chart 7 represents in graphic form the quantitative fluctuations of both the red and white blood cells selected from the many examinations that were made on patient E. G. during the period in which thoracoplasty was performed and for almost a year following this event. This was a female patient, age 27 years, who had had a history of a "cold" in March, 1930 followed by pleuritic pains three weeks later. Section of the phrenic nerve had been done the latter part of 1930 and after almost two years of convalescence the patient returned to work. In May, 1932, the patient was said to have had influenza and stopped work. Subsequently, two attempts at pneumothorax were unsuccessful. She was admitted to our clinic on October 10, 1933, for

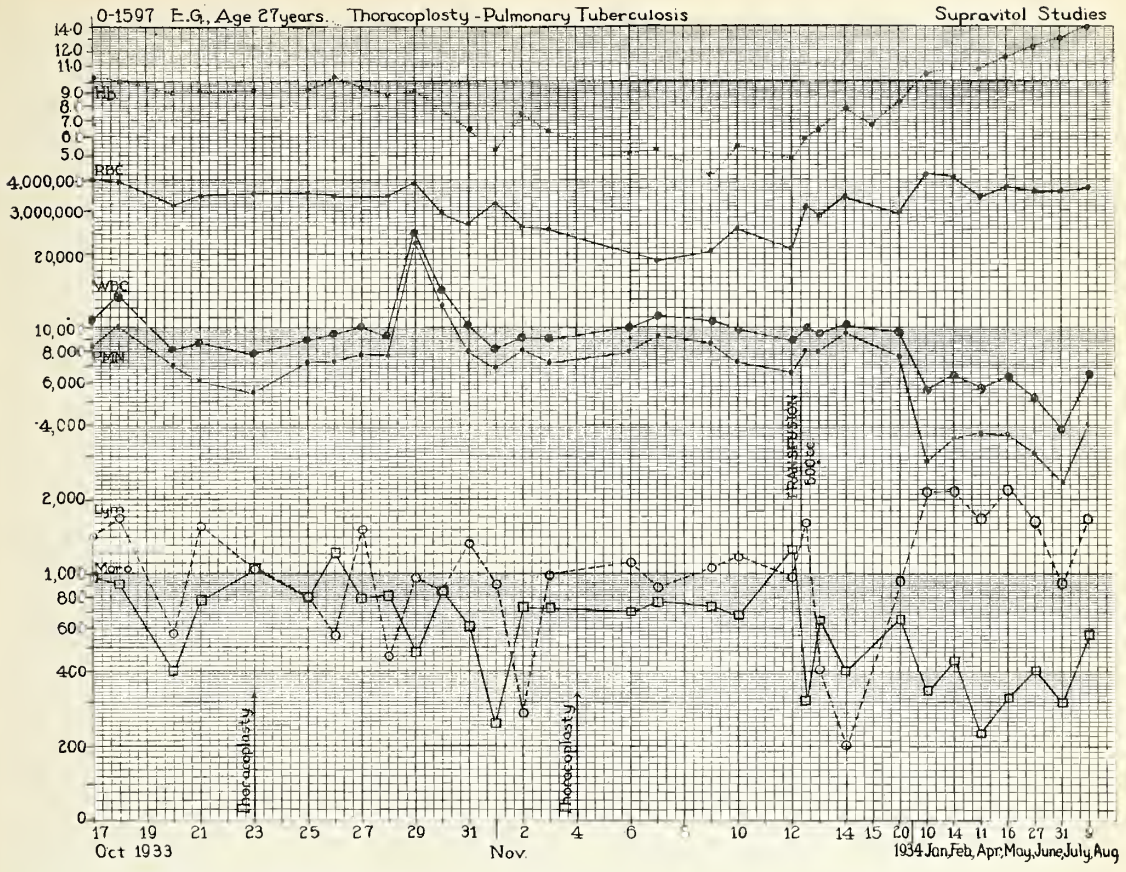


Chart 7. Quantitative fluctuations of the red and white blood cells in patient E. B. before, during and following thoracoplasty. The values for the white blood cells were secured with the supravital technique and are plotted upon semi-logarithmic paper.

thoracoplasty. Upon admittance there were râles over the entire left lung. The *X*-ray showed an apical cavity and fluid in the left chest to the level of the eighth rib posteriorly. Pulse and temperature were moderately elevated and loss of weight was quite marked.

Examination of the blood curves prior to surgical intervention showed a low value for hemoglobin (9 gms. per cu. mm. of blood), neutrophilic leucocytes considerably over 5,000 (the upper limit of normal as established by Medlar), the lymphocytes below the critical level of 2,000 and the monocytes well over the critical level of 800. The interpretation of these values was to the effect that toxemia had been prolonged and severe with no evidence of abating (hemoglobin dangerously and persistently low), that additional cavitation was impending (high values for the granulocytes) that the tuberculous process was spreading (high values for the monocytes) and that very little healing was occurring (low values for the lymphocytes).

These conclusions were substantiated by analysis of the qualitative values for these cells (chart 8) in that both the Arneth index for the neutrophils and the Wiseman lymphocyte index showed strong regenerative shifts to the left. Thoracoplasty was performed in two stages. On Nov. 12, a blood transfusion was employed to combat shock and a severe postoperative anemia (the hemoglobin had now fallen to 5 gms. per cu. mm. of blood). Almost immediately following transfusion, all indices reflected improvement, and the patient was discharged to her home on Nov. 20.

Subsequent blood examinations obtained at monthly intervals show the return of all cell values to normal. Clinical and roentgenological examinations show a completely arrested disease. Note that the qualitative values for the granulocytes and lymphocytes did not return to normal until August 9, 1934, indicating that activity had not completely disappeared until that date, an important point in the management of this patient, as regards exercise. The improvement in hemoglobin is particularly outstanding and provides an added index of the satisfactory recovery of this patient.

Chart 9 represents data from a single blood examination of a colored patient (J. T.) who is known to have had pulmonary tuberculosis for at least a year. During this time the usual medical measures had been employed with apparent success in that gain in weight and strength had been exceptional. Examination on July 25, 1934, failed to reveal clinical or roentgenologic evidence of tuberculous activity. The blood findings were interpreted as follows: the hemoglobin level and total red blood cells were satisfactory. The total number of neutrophilic leucocytes was within normal limits; there was, however, an unmistakable shift to the left in the qualitative characteristics of these cells that usually foreshadows an increase of activity of the lesion. The lymphocytes were low in absolute numbers (785 per cu.

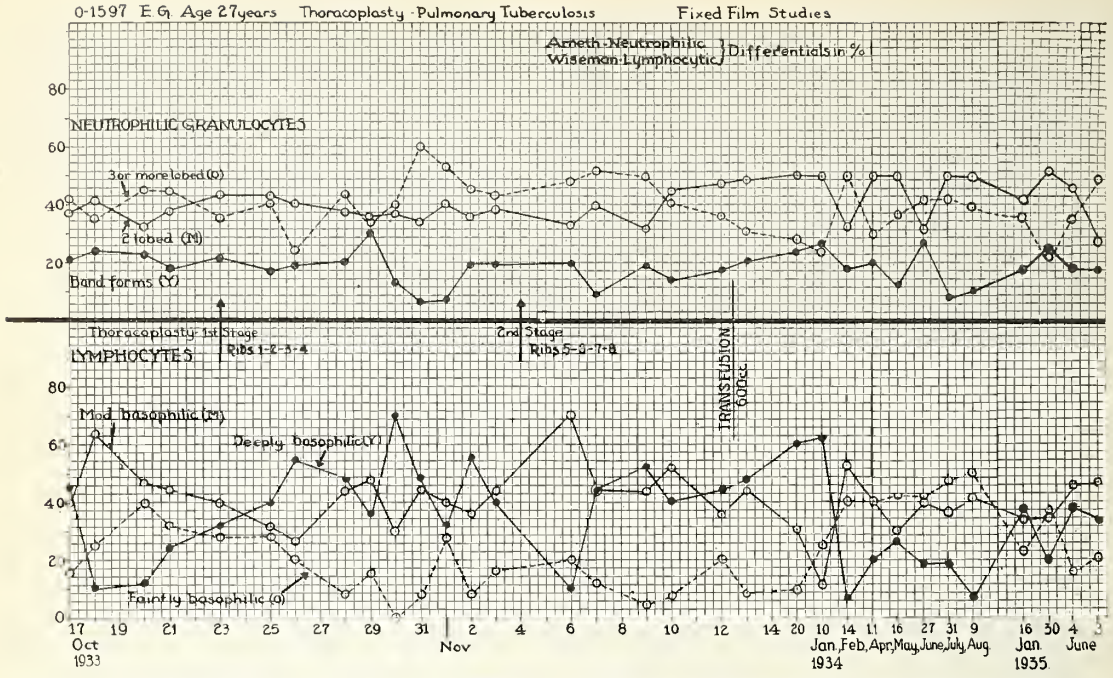


Chart 8. Qualitative fluctuations of the neutrophilic leucocytes (upper half of chart) and the lymphocytes (lower half of chart) in same patient, (E. G.) as Chart 7. The values plotted hereon were obtained from films fixed and stained with the Wright's Giemsa technique, and are shown on plain graph paper.

mm. of blood) indicating unsatisfactory healing. The qualitative changes in the lymphocytes were outstanding, showing moderately severe regenerative shift to the left which we interpret as a demand for lymphocytes greater at the moment than the lymphocytogenic tissues can supply. The monocytes were high and the M/L index was elevated. The significance of this latter finding lies in its reflection of epithelioid proliferation still proceeding and progressing out of all proportion to the amount of regressive healing taking place. The maintained increase in erythrocyte sedimentation velocity further substantiates the continuing activity and toxemia still present in this case. As a result of the interpretations based upon the blood examination, the conclusions drawn from the clinical findings were completely reversed and the recommendation was made that inasmuch as prolonged medical management had not proved effective, pneumothorax or phrenic section should be performed.

The foregoing cases, taken at random from a much larger series and representing both the medical and surgical aspects of tuberculosis which we have studied over the past four years, serve to demonstrate, even though somewhat summarily, the application of the principles of modern hematology to the problems of clinical tuberculosis. It has been demonstrated in many cases that information may be obtained about the reaction of the patient to his disease that could be secured in no other way; in others the verification of impressions obtained by clinical examination has been obtained.

In all cases the added data furnished by adequate and modern hematological examination has been useful and has justified from a purely practical standpoint the effort in making such observations. The time honored blood "count" can no longer suffice in the light of modern hematologic concepts of the pathologic-physiology of the cellular structure of the organism. "Blood counting", with its routine inaccuracies and limited interpretations, should be supplanted by the scientific study of the blood from which an increasingly important and significant fund of diagnostic and prognostic data may be anticipated by the physician.

CHART 9

J. T.

July 25, 1934.

W.B.C.	4350
P.M.N.	52% Qual. (T.-20, 2-60, 3-20)
P.M.E.	16%
Lympho.	16% Qual. (Y.M.O. 15: 60: 25)
Mono.	16— No. Qual. Changes.
M/L Index	1
R.B.C.	3,910,000
Hgbn.	12.3 gm.
Sed. Vel.	41 mm. in 50 min.

Chart 9. A summarization of the principle hematologic findings as obtained from a single examination of patient J. T.

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III. COLLAPSE THERAPY

By George M. Curtis, M.D.

*C. H. Benson, M.D., F.A.C.P., and Louis E. Barron, M.D., Columbus, Ohio, Collaborators.

COLLAPSE therapy for pulmonary tuberculosis produces immobilzation and compression of the diseased lung. Rest is thus attained. Closure of the sputum producing cavities is thereby accomplished. This makes it possible for the patient's own powers of resistance and healing better to overcome the disease.

This consideration, of the *principal surgical procedures* utilized in collapsing and thus in resting the tuberculous lung, is based upon our experience in the University Hospital during the past two years. The indications for different available collapse procedures are varied. They are best individualized after a thorough investigation of the patient. In this connection, the aid of a physician, experienced and competent in the management of tuberculosis, is paramount. Pneumothorax, oleothorax, the various forms of phrenic nerve interruption, pneumonolysis with the aid of the thoracoscope or by open thoracotomy, plombage, and thoracoplasty each produce collapse by differing methods. Their end results are correspondingly varied. As a consequence the choice of one or of a combination of the various procedures available is based upon a number of considerations.

Pneumothorax means air within the pleural cavity. Concerned are the elastic lung, the rigid chest wall, the movable mediastinum and the moving diaphragm. Varying degrees of collapse may consequently be obtained. Pneumothorax may occur spontaneously, the air entering from an opening in the diseased lung. Certain patients thus aid in healing their own disease. Nature thus pointed to the first use of collapse therapy.

Pneumothorax is administered by injecting air into the pleural cavity under controlled conditions. This procedure, although manipulative, is usually accomplished by the physician. To be most effective the pleural space must be free. *Adhesions* often form between the lung and the chest wall and diaphragm. They are usually present in long standing disease. They are variable in their extent and nature, thus obliterating in varying degrees the pleural cavity. Pneumothorax thus becomes impossible. When adhesions involve only a part of the lung, a partial pneumothorax may still be affected. The extent of pneumothorax induced is readily determined by the fluoroscope and particularly by stereofilms.

In order to maintain the collapse the air must be occasionally replaced, since it is gradually absorbed. Thus "refills" are necessary. In an attempt to obviate the necessity of repeated injections, a heavy oil has at times been introduced instead of the customary "gas." This procedure is known as *oleothorax*. The heavier oil then maintains the collapse. There are certain disadvantages to this form of therapy. As a consequence there are definite indications for its limited use.

Phrenic nerve interruption is the simplest of the operative collapse measures. It results in paralysis of the corresponding half of the diaphragm. The constant piston-like action of the diaphragm then ceases and rest is attained. The paralyzed diaphragm rises to its customary high position of rest. It subsequently rises even higher as a result of intra-abdominal pressure and consequent changes in the position of the underlying viscera. A partial collapse of the corresponding lung is thus produced. It is estimated that up to one-third of the lung is thus compressed.

There are *various forms of phrenic nerve interruption.* The nerve is exposed in the neck, identified by its characteristic position on the anterior scalene muscle, and proved by certain tests. It may then be injected, sectioned, crushed, or actually evulsed. The resultant diaphragmatic paralysis may be made temporary by crushing the phrenic nerve, or permanent by actually twisting it out. This was originally known as "exairesis." Injection is usually of but transient effect, and is rarely, if ever, used in the treatment of pulmonary tuberculosis. Section may fail due to the presence of accessory phrenic nerves. Exairesis, if successful, is final. "Phrenic crush," as outlined by Alexander, is becoming more widely appreciated and used, since it results in a temporary paralysis of about six months duration. Phrenic nerve operations are also valuable adjuncts preliminary to the more extensive collapse procedures.

Pneumonolysis means essentially the freeing of an adherent lung. It attempts to divide and free cords or bands of adhesions between the lung and the chest wall. Thereby the diseased lung is permitted further to collapse under the influence of pneumothorax. Open pneumonolysis is accomplished by directly entering the pleural cavity through an open thoracotomy. The adhesions are then divided under direct vision. Or, by means of the thoracoscope, electrocautery instruments are passed into the pleural space and the adhesions are sectioned. Successful internal pneumonolysis thus permits subsequent adequate collapse by pneumothorax.

Plombage is a form of collapse therapy induced by packing. It is not so frequently used as others of the collapse procedures. It has been employed as a less radical procedure than thoracoplasty in collapsing apical cavities. Again, it is used in attempting to obliterate residual cavities subsequent to the more conservative form of thoracoplasty. Paraffin, muscle, or fat are most commonly used to make the compressing pack. Paraffin behaves subsequently as a foreign body, occasionally with unfavorable results. Plombage is not an entirely satisfactory collapse measure.

Thoracoplasty designates any one of a group of plastic operations upon the thoracic wall. It has long been a recognized operative procedure. Formerly it was particularly used in attempts to collapse the cavities of chronic empyema. It consists in removing varying segments of the different ribs, together with various amounts of the attached soft tissues. The unsupported chest wall then collapses, compressing the underlying lung. Immobilization and consequently rest follows.

The *modern thoracoplasty* as developed by Sauerbruch, and as used by Archibald, Graham and Hedblom, has grown out of the older Estlander operation. Since the pleura is not concerned in the procedure it is called "extrapleural." The incision is usually along the spine, and posterior rib segments are customarily removed; consequently the term "paravertebral." The common operation now done is thus specified as an "extrapleural paravertebral thoracoplasty."

Extensive removal of rib segments is followed by a soft, flaccid chest wall. The rib periosteum, however, is spared and remains behind. In time it regenerates bone, and thus the collapsed thoracic wall eventually stiffens. This is ordinarily of obvious advantage. On the other hand, if regeneration ensues before adequate collapse has occurred, residual cavitation may remain. *Bone regeneration* may be prevented by painting the exposed periosteal rib beds with ten per cent formalin. This is of advantage in a thoracoplasty done in multiple small stages over a long period of time.

Thoracoplasty in its variations is commonly regarded as the more formidable type of operative management. Its application in the treatment of pulmonary tuberculosis is more recent. Its results, however, warrant giving it a secure place among the useful forms of collapse therapy. It has become safer owing to the division of the entire operation into a series of lesser procedures called "*stages.*" It presents a fruitful field for clinical investigation. As a consequence we wish to devote the remainder of this paper to its consideration.

As a basis for a more extensive discussion we wish to present the principal results of an *investigation of* the first *twenty patients* upon whom we have accomplished thoracoplasty in the University Hospital. This is a small series. Nevertheless, it has been extensively investigated by our group. Dr. Charles A. Doan has presented to you some of the bacteriologic results. Dr. Bruce K. Wiseman has discussed the accompanying blood findings. More detailed reports than these are in press. The tabulated data and summaries of this cooperative study will be published elsewhere.

Fourteen of the twenty patients were referred to us from surrounding sanatoria. The remainder were from the practice of one of our group (C.H.B.) Eight were males and twelve were females. The ages ranged from 16 to 57 years. All twenty presented evidence of cavitation. In sixteen this was mainly apical in location. In two it was basal. All twenty were producing sputum, which was positive in seventeen. In three we found no tubercle organisms, although others had repeatedly done so. Sixteen were febrile. Fifteen had an increased pulse. Two had frankly bilateral disease. Thirteen of the eighteen patients with unilateral disease had left lung involvement.

The immediate previous activity of the twenty patients varied. Six were on absolute bed rest. Ten were allowed minimal activity. Two were active.

Patients entering the hospital for thoracoplasty have usually had *previous collapse therapy*, principally pneumothorax or some form of phrenic nerve interruption. Pneumothorax may have been attempted and may have failed owing to extensive adhesions. Likewise section of the phrenic nerve may have been unsuccessful owing to the presence of unrecognized accessory branches. Four patients came in with a residual pneumothorax. Eleven had some form of previous phrenic interruption. One patient had had a Schede type of thoracoplasty.

There are a number of conditions which should be fulfilled before advising thoracoplasty. The patient should show evidence of an ability to heal pulmonary tuberculosis. Such facts are obtainable. The indications are best individualized after a thorough investigation of the patient. The outlook is brightest in those patients with but one

lung involved. Nevertheless, thoracoplasty may be safely accomplished on certain selected patients with bilateral disease.

The *aim of thoracoplasty* is to obtain a sufficient collapse of that portion of the lung which is diseased. Since the lung may be partially or wholly involved, either a partial or a complete thoracoplasty may be necessary. In a complete thoracoplasty segments of the first eleven ribs are resected. This was accomplished upon eight of our patients. The lengths of these segments vary. This depends upon the type of operation chosen, the conservatism of the operator, and the extent of collapse which seems necessary. In the eight patients the entire length of the excised rib segments varied from 90 to 151 cm. and averaged 131 cm. An adequate complete thoracoplasty thus removes considerably more than a yard of ribs.

Partial thoracoplasties were accomplished on nine patients. During these, from four to nine rib segments were excised. In seven of the patients, segments of from seven to nine ribs were removed in two stages. In the other two patients the proposed thoracoplasty could not be completed owing to the development of complications.

Apical thoracoplasty is a partial form designed particularly for the collapse of apical cavities. The upper three or four ribs alone are removed. The resection is also more extensive. Thus in our three apical thoracoplasties up to 52 cm. of the shorter upper ribs were resected. It is readily possible to excise all of the upper four ribs. Too, bilateral apical thoracoplasty is now an accomplished fact.

In all, 47 *stages* were made on the twenty patients. This is an average of 2.4 per patient. Three of the thoracoplasties were completed in one stage. Six were made in two stages. Seven were accomplished in three; and two in four stages. Two of the thoracoplasties were not completed as planned. Phrenic nerve interruption was used as an accessory collapse measure on five patients.

One patient had had elsewhere a Schede type of thoracoplasty. This had become infected, and subsequently a large defect in the chest wall with a bronchial fistula had resulted. Since in the Schede thoracoplasty the periosteum is removed, together with the ribs and the adjacent soft tissues, a flaccid chest wall was also present. The Schede thoracoplasty was incomplete, hence an apical thoracoplasty was first accomplished to complete the collapse. It was then necessary to close the bronchial fistula, and finally to make a two stage plastic restoration of the considerable defect in the left thoracic wall. Thus, in all, an average of nearly three operations per patient seemed necessary, in carrying out collapse therapy.

The *complications* encountered during this series of 55 collapse operations may be classified as (a) controllable, (b) severe and (c) fatal. Peripheral vascular collapse, mediastinal shift, progressive anemia, hemoptysis and atelectasis in the contralateral lung were each encountered but once. Twice occurring controllable complications were cyanosis, wound infection, and discomfort with some stiffness in the arm and hand. There were three severe complications. One patient developed a contralateral pneumonia. This resulted in activation of the good lung, so that the proposed thoracoplasty was not completed. A second patient developed an axillary thrombophlebitis. There was a questionable pulmonary embolus. Eventually she completely recovered. A third developed what for want of a better term has been called "acute auto-tuberculinization." This was eventually controlled.

The one fatality in the series was due to severe "autotuberculinization," together with contralateral pneumonia. This patient was known to have frankly bilateral disease. But a moderate reaction followed the first stage. A severe generalized reaction ensued following the second stage. There was evidence of allergy. This was the second incomplete thoracoplasty.

The *hospitalization period* varied. In twelve uncomplicated cases it was from 25 to 65 days and averaged 37 days. In eight complicated cases it ranged from 33 to 120 days, averaging 65 days. Nearly all of our patients were hospitalized longer than usually necessary owing to the control studies our group was making. From the hospital thirteen patients returned to sanatoria. Six returned to their homes.

At the time of our first check-up, from six to nineteen months following the last thoracoplasty, all nineteen patients were living. Twelve were on unlimited activity. Six were back at work. Six were at home or in the sanatorium. Five were still kept on restricted activity. Two were at absolute bed rest.

During the summer of 1934 all nineteen patients were brought back to the University Hospital for a thorough investigation of the results of thoracoplasty. The last stage had been completed from seven to twenty months previously. All studies were made under controlled hospital conditions.

Sputum production had decreased in all nineteen patients. Four now raised no sputum. In eight the amount was minimal. It was moderate in five and profuse in two. All nineteen patients had originally had a positive sputum. At our check-up only three were found to be positive. Thus thirteen of the patients had, under our observation, changed from a positive to a negative sputum.

Upon entering the hospital for thoracoplasty, sixteen of the patients were febrile. During the period of hospital check-up it was observed that a half of these had become afebrile. Originally,

fifteen patients had presented an increased pulse. Subsequently, after thoracoplasty, this had decreased in ten. In five it was unchanged. In four it had increased. Seven patients had gained weight. In five the weight had remained the same. In seven weight loss had ensued. The latter fact is not surprising since the patients originally sent us from sanatoria were in an excellent state of nutrition. Upon returning to a more active life some weight loss had followed. In sixteen of the nineteen patients the good lung was clinically inactive.

As a *final evaluation*, six patients were socially and economically rehabilitated. These may be regarded as "cures." Six were definitely improved. Three were improved. Three presented no change. One was definitely worse. There had been one death.

Collapse therapy thus offers not only relief to the patient, but prevention to society. Sputum producing patients are "sowers of the seed." They are thus a menace to themselves, to their families, friends and attendants. Collapse therapy usually is followed by a lessening of sputum production. Often the sputum ceases or becomes negative. The benefit is obvious. The results of thoracoplasty as a collapse measure are excellent. It is becoming a safer procedure. Two-thirds of those patients for whom it is indicated, and upon whom it is accomplished, are improved. One-third are even able to return to their former life. Thus, there is reclaimed to society a group of individuals otherwise permanently invalided.

The fact remains, however, that collapse therapy leaves behind diseased lung. Is the actual resection of all or of portions of a diseased lung to become a safe procedure? Recent clinical and experimental work yield added hope. *Pneumonectomy* is not a form of collapse therapy. It will actually remove the disease.

In conclusion, may we emphasize that the ideal treatment of tuberculosis is eradication. Prevention is of primary significance. The physician is often able successfully to cope with the disease. Nevertheless, collapse therapy is a valuable accessory. By this method surgery now offers new hope to a class of patients upon whom the best of medical management has failed.

THE CLINICAL ASPECTS OF ALKALOSIS

By JOHN HART DAVIS, M.D., CLEVELAND, OHIO

THE clinical aspects of alkalosis are rather commonly overshadowed by its more abstract and academic features. The average medical man looks upon it as a "laboratory disease" and not a clinical entity with a tangible origin, real symptoms and signs, and frank therapeutic indications and contraindications. The chemist has largely dominated its discussion in the past. He has emphasized its physicochemical aspects without knowing precisely how they might be useful. Yet out of his contributions have developed certain new concepts of diagnosis and treatment that challenge our ultimate interest and our best judgment. It is this phase of the subject I hope to develop in today's discussion. However, it seems advisable, first, to review the basic features of alkalosis before undertaking to elaborate upon its clinical aspects.

Alkalosis occurs when there is an increase in the fundamental ratio of "base" bicarbonate ($BHCO_3$) to carbonic acid (H_2CO_3). This ratio normally is $\frac{BHCO_3}{H_2CO_3} = \frac{20}{1}$ and maintains the blood and body fluids in a constant state of mild alkalinity at a pH of 7.40. If this ratio is changed, for example, to $\frac{40}{1}$ or $\frac{20}{1/2}$ there is a prompt increase in alkalinity followed by alkalosis.

Read before the Section on Obstetrics and Pediatrics, Ohio State Medical Association, at the 88th Annual Meeting, Columbus, October 4-6, 1934.

Theoretically, such changes occur when "alkali" is increased in the body from any cause, or when "acid" is lost. Actually there are three clinical origins of alkalosis:

(1) The excessive ingestion of "alkali"—usually some form of bicarbonate or citrate.

(2) The loss of carbonic acid gas

$$(H_2CO_3 \rightarrow H_2O + Co_2\uparrow)$$

by hyperventilation.

(3) The loss of chlorides (HCl) by vomiting, lavage, or gastric fistula.

The first two are perfectly obvious. In the one instance the normal "acid-base" ratio of $\frac{20}{1}$ is changed by an increase in the numerator ($BHCO_3$), in the other by a decrease in the denominator (H_2CO_3). In either instance there is a relative increase of bicarbonate with a consequent increase of alkalinity. On the other hand, the mechanism of alkalosis resulting from the loss of chlorides (HCl) is not immediately clear, but finally resolves itself into a simple substitution of the bicarbonate anion (HCO_3^-) for the lost chloride ion (Cl^-). Total "base" bicarbonate is correspondingly increased and alkalosis occurs.

Clinically, the most common of the causes of alkalosis is the loss of chlorides (HCl) by vomiting. The kidneys, except in disease, will excrete all ordinary excesses of "alkali". Hyperventilation is a clinical rarity except in encephalitis and

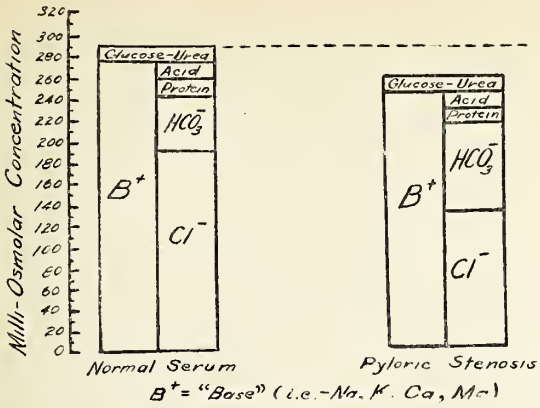


Diagram showing normal distribution of serum "electrolyte" and changes that occur in pyloric stenosis. Note decrease of Cl—increase of HCO_3—and slight decrease of "total base" (B+).

hysteria. Vomiting, on the other hand, associated with pyloric obstruction or "high" intestinal obstruction, is not an uncommon feature of pediatric practice and assumes, therefore, an important place in our discussion. It must be kept in mind for clinical use that vomiting from "high" obstruction results in a more effective loss of chlorides (HCl) than vomiting from "low" obstruction or no obstruction.

A laboratory diagnosis in alkalosis is a comparatively simple matter in an institution equipped to do the necessary blood chemical estimations (particularly "total chlorides", plasma CO_2 and pH). On the other hand it is often impracticable at the bedside to do, or to have done, any such studies. It would thus seem that the practitioner of medicine must frequently be thwarted in his clinical consideration of the disorder. Fortunately that is not altogether true. There are three quite characteristic clinical symptoms which, if kept in mind and correlated with other significant features, will give worthwhile help at the bedside. These are:

(1) Slow, shallow respirations with periods of apnoea (resembling the Cheyne-Stokes type of respiration).

(2) A mild ashen-gray type of cyanosis indicating anoxemia.

(3) Tetany with rigidity and convulsions.

The first symptom is the natural result of the compensating mechanism which maintains the normal $\frac{BHCO_3}{H_2CO_3}$ ratio of $\frac{20}{1}$. If, as in alkalosis, the ratio becomes abnormal, e. g. $\frac{40}{1}$, then the rate and depth of respirations decrease to "hold" CO_2 in solution in the plasma until the ratio shall approximate $\frac{40}{2}$ (the equivalent of $\frac{20}{1}$) which would represent a compensated alkalosis. If the ratio is $\frac{20}{\frac{1}{2}}$ then again slow, shallow respirations would "hold" CO_2 in solution and tend to restore the normal ratio of $\frac{20}{1}$. The symptom thus has its explanation in the fundamental chemistry of the disorder.

The symptom of anoxemia accompanied by a mild ashen-gray type of cyanosis, occurs as a result of the slow, shallow respirations already noted. It is directly due to a total decrease in the minute volume of air which results in a corresponding decrease in oxygen—carbon dioxide exchange.

Tetany with rigidity and convulsions as a feature of alkalosis is best explained by the following equation:

$$\frac{Na^+ + K^+ + OH^-\ \text{(Irritant ions)}}{Ca^{++} + Mg^{++} + H^+\ \text{(Depressant ions)}} = K\ \text{(Constant)}$$

Any increase in the numerator or any decrease in the denominator of this equation will result in an increased irritability of the nervous system. Ordinarily, in alkalosis, the only change is an increase in the hydroxyl ion (HO^-) or a decrease in the hydrogen ion (H^+). As "alkali" increases, the calcium and magnesium go out of the ionized state and more and more into a molecular state and thus fail to balance the irritant effect of sodium and potassium. Tetany, with rigidity and convulsions, then may follow.

The treatment of alkalosis involves certain rational indications as well as certain important contraindications. It is indicated to:

(1) Discontinue all "alkali" by mouth or otherwise.

(2) Urge water or other diuretics in an effort to increase the excretion of bicarbonate through the urinary tract.

(3) Institute emergency measures for the relief of tetany if present.

(4) Combat anoxemia and the symptom of slow, shallow respirations by the administration of a carbon dioxide—oxygen mixture.

(5) Give morphine sulphate or other effective sedatives in order to control hyperventilation—if present as a primary cause.

(6) Restore electrolytes, especially chlorides —if there is a deficit—by some one of the infusion routes.

(7) Intervene surgically in the relief of obstruction—if present or suspected.

It is strictly contraindicated to:

(1) Give any additional "alkali."

(2) Employ any other type of respiratory stimulant than a carbon dioxide—oxygen mixture as it only serves to "wash out" more CO_2, thus increasing the alkalosis and resulting not infrequently in death.

The positive indications for treatment just noted do not require any particular elucidation or explanation, except perhaps for tetany with

rigidity and convulsions, and anoxemia accompanied by slow, shallow respirations.

Tetany is treated most effectively by the intravenous administration of $CaCl_2$ (¼ to ½ cc. of a 5 per cent solution per kilogram of body weight). The procedure is ordinarily prompt to relieve and free of danger but not without some hazard as the solution is so irritant that it will cause sloughing if any portion of it is injected subcutaneously. Calcium gluconate may be substituted safely but is lacking in the chloride ion which $CaCl_2$ supplies. Magnesium sulphate (2 cc. of a 10 per cent solution of the anhydrous salt per kilogram of body weight) may be given intramuscularly and has a relatively prompt action in relieving the condition but has a definite depressant effect on respiration. It must, therefore, be used with some degree of caution. HCl and NH_4Cl by mouth are slower but useful.

Anoxemia accompanied by slow, shallow respirations is effectively and safely treated by the administration of a carbon dioxide—oxygen mixture (5 to 10 per cent CO_2 in oxygen if a tight fitting mask is used—30 per cent CO_2 in oxygen if a catheter or funnel is employed). By this method CO_2 is restored to the plasma in normal concentration, thus tending to re-establish the normal bicarbonate-carbonic acid ratio of . The respiratory rate approaches normal, anoxemia is corrected, and metabolic functions in general improve. Any other form of respiratory stimulant, especially the use of caffeine or alpha-lobelin, not only exaggerates the alkalosis but is actually dangerous as I have already noted.

In this connection I may say that I know personally of two infants with hypertrophic pyloric stenosis, manifesting all the cardinal signs of alkalosis, i. e., slow, shallow respirations, anoxemia, and tetany, who were given alpha-lobelin to stimulate the respiratory rate and improve oxygen exchange. Both infants hyperventilated momentarily, had convulsions and died within a few minutes. I assume they died of cardiac tetany as a result of increased alkalosis.

I have in mind four other cases illustrating in one way or another certain further points I would like to bring out relating especially to diagnosis.

A child of 15 months in the course of convalescence from whooping cough, developed hyperpnoea and convulsions. On account of seeming "air hunger" a preliminary diagnosis of acidosis was made and generally accepted by the hospital staff. Exception was made, however, by a man conversant with the vagaries of alkalosis who noted that although the child had hyperpnoea, it had also tetany with rigidity, carpo-pedal spasm, and a positive Chvostek sign. He concluded, therefore, that the child did not have acidotic breathing but hyperventilation from a whooping cough encephalitis and prophesied an alkaline pH, which was confirmed. The child was given an effective sedative to slow down the respiratory rate and recovered shortly from the encephalitis as well as the alkalosis without any further incident.

An infant four days old was vomiting and otherwise doing poorly. Its respiratory rate was strikingly decreased, ranging between 6 and 12 per minute, and characterized by shallowness and short periods of apnoea. It showed some slight rigidity but no tetany or convulsions. Following the parenteral administration of sodium chloride by the subcutaneous route the respiratory rate rose temporarily to 24 to 30 per minute but later dropped as the vomiting grew worse. On the ninth day the infant died. An ante-mortem diagnosis of "high" intestinal obstruction was confirmed at autopsy when a complete atresia of the duodenum was found just proximal to the outlet of the common bile duct. There were at least two observations in this case that could be correlated to help fix the site of obstruction. The first was the fact that the infant had characteristic meconium stools with no trace of food throughout the nine days of its life, which would suggest obstruction proximal to the bile duct. Second, was the fact of vomiting with symptoms of alkalosis, signifying a considerable loss of hydrochloric acid. To lose chlorides in such a degree meant one thing—"high" obstruction without opportunity for absorption of chlorides along any portion of the jejunum or ileum. That the diagnosis was confirmed is at least a partial justification of the deductions from the particular evidence.

Two children with intestinal obstruction were seen in the hospital at the same time; one a boy of nine years, the other a girl of eight. They were vomiting with equal frequency and vigor. The boy had slow, shallow respirations, (6 to 12 a minute,) with definite periods of apnoea, definite ashen-gray cyanosis with anoxemia, and general muscle rigidity. He had no evident tetany and no history of convulsions. The girl, on the other hand, was breathing at a normal rate (20 to 24 times a minute), had a satisfactory color and no tetany or rigidity. Abdominal palpation in both children revealed a somewhat doughy mass in the right side without suggesting specific localization in either instance. Neither child was having bowel movements.

A pre-operative diagnosis of pyloric or duodenal—("high")—obstruction was made in the boy and at operation a mechanical obstruction was found involving the first third of the duodenum. A pre-operative diagnosis of "low" obstruction, probably intussusception, was made in

the instance of the girl and at operation intussusception was found projecting the caecum and ilio-caecal valve into the colon.

The interesting thing about these two cases, and the thing I wish to bring out especially, is the fact that the symptoms of alkalosis may be utilized to differentiate between "high" and "low" intestinal obstruction. The boy with all the cardinal symptoms of alkalosis was surely losing HCl abundantly. Only a "high" obstruction (pyloric or duodenal) could account for it. The girl with no symptoms of alkalosis was evidently not losing HCl in any significant amount. Evidently chlorides were being "taken up" along the course of the jejunum and ileum before vomiting occurred. The obstruction then must be well along the tract or "low" and logically at the junction of the caecum with the colon.

It is not generally likely, as in the two instances just cited, that the exact site of the obstruction can be predicted, but I feel that this particular line of reasoning has wide clinical application and real possibilities.

CONCLUSION

(1) The causes, symptoms, and rational treatment of alkalosis have been reviewed.

(2) Certain contraindications in treatment have been pointed out, especially the use of "alkali" by mouth, and the use of respiratory stimulants other than carbon dioxide—oxygen mixtures.

In this connection I would condemn the rather general and widespread use of sodium bicarbonate water in all types of vomiting in children and would suggest instead the use of orange juice, Karo water, or dextrose solution.

(3) The successful application of the basic concepts of alkalosis in the differential diagnosis of intestinal obstruction has been reported. It is hoped the principles involved may find a wider application in clinical medicine.

10515 Carnegie Ave.

DISCUSSION

W. B. TAGGART, M.D., Dayton: I am certain we have all enjoyed the clear cut presentation of the subject of alkalosis by Dr. Davis.

His point of using the difference in clinical pictures presented by the presence or absence of alkalosis in differentiating between high and low intestinal obstruction is an additional diagnostic aid from which we can all profit.

Hartman has recently called attention to the relative infrequency of clinical alkalosis in cases of pyloric obstruction, either due to a stenosis or spasm and suggests the explanation that probably gastric acid secretion is at low ebb, hence though vomiting may be persistent, little acid in the form of chlorides is actually lost.

One other clinical entity in which we may frequently see clinical alkalosis is so-called cyclic vomiting, where as we all know vomiting may persist, if not controlled, over several days.

Other types of pyloric or high obstruction where loss of gastric secretion may lead to alkalosis and tetany may be classed as anomalous defects in the structure of this portion of the upper intestinal tract. One such patient, a white female infant of six months, with a history of periodic bouts of vomiting and rather indifferent progress in the direction of growth and development was seen at the end of one such bout with the following salient clinical findings:

The infant was irritable, dehydrated with marked facial or Chvostek phenomena. A latent Trousseau or typical obstetrical hand was bilaterally present. A KOC of three was present. There were no gross evidences of rickets.

The child was given atropin sulfate and placed upon hydrochloric acid milk. (Boiled half skimmed milk 750 cc.) and (10th normal hydrochloric acid 250 cc).

Within 24 hours all former clinical evidences of tetany had disappeared. The above feeding was continued for two or three days longer. During the rest of her hospital stay vomiting occurred, but only irregularly. She was discharged home. Some few weeks later she was admitted after a similar history of vomiting in a moribund condition and promptly died.

Post-mortem examination revealed a kinking of the first portion of the duodenum by an anomalous peritoneal band. There were no evidences of rickets.

—OSMJ—

Six Ohio Cities Included in Chronic Disease Survey

Six Ohio cities are included in the nation-wide survey of chronic and disabling diseases now being conducted by the United States Public Health Service, using 30,000 workers selected from relief rolls.

A complete house-to-house canvass will be made in Franklin, Lima and Wilmington, but only samples of the population will be studied in Cleveland, Cincinnati and Columbus.

The blank to be used by the canvassers calls for information concerning the names, ages and occupations of those in the household; whether or not they have ever suffered from asthma, Bright's disease; bronchitis, cancer, tumors, varicose veins, or any other chronic disease; name of the doctor and hospital where they were treated; length of illness; whether a member of any sick-benefit association; housing conditions, etc.

It is anticipated that the information obtained will be checked with physicians who attended the patients.

Attention is called to an editorial on this health survey, and a facsimile of the blanks to be used and other data, in the October 5 issue of *The Journal of the American Medical Association.*

—OSMJ—

Death tolls on Ohio highways reached an all-time record last year with 2100 Ohioans losing their lives in accidents involving automobiles, 31 fatalities for each 100,000 of the state's inhabitants. This is an increase of 15.2 per cent over the rate for 1933.

CONSERVATISM IN GYNECOLOGY*

By VIRGIL S. COUNSELLER, M.D., Rochester, Minnesota

TO SOME it may seem that conservatism in gynecology is a subject that does not merit much discussion, but to others, who perhaps are more familiar with the general practice at home and abroad, the urgent necessity for keeping it before the profession is apparent. You might ask why this is true. One striking reason is that gynecology constitutes about 25 per cent of the average physician's practice. Furthermore, the mortality in pelvic surgery is definitely lower than for other types of abdominal surgery when the usual surgical principles and standardized technics are employed, so that the surgeon may not feel the same degree of hesitancy in undertaking pelvic operations that he shows, for instance, in operations in the upper portion of the abdomen. For these reasons pelvic surgery is often performed when there is only the slightest indication for it, and at times when there is no real indication at all. It should therefore be remembered that the mortality for any operation reaches its maximum in the hands of careless or untrained men.

C. Jeff Miller has often quoted a remark, which was attributed to Howard Kelley, to the effect that surgery, developing in the hands of men, has dealt too lightly with mutilating operations on women, and that if the situation were reversed for several decades, women performing the operation and men suffering the mutilation, there would undoubtedly be a larger number of men than there are now in favor of conservatism. There is a general tendency to disregard the fact that the whole scheme of existence of some women depends on the state of their pelvic organs.

Conservatism in gynecology not only infers conservation of the sexual organs, but preservation of their functions as well. Since destruction of these functions does not endanger the patient's life, function is sometimes carelessly destroyed, not because it is necessary to destroy it to effect a cure, but because it is the easiest way to perform the operation. Such a procedure is illogical and should be condemned.

Many factors may influence the management of gynecologic conditions, such as the age and social and economic status of the patient. For example, a conservative operation that entails the risk of a later secondary operation may be entirely justified in the case of a well-to-do woman who has recently been married, but it would not be justified for a woman approaching the menopause, one who was the mother of a family, or one whose livelihood depended on her own efforts. The type of lesion may also modify the degree of conservatism in a given case. For example, partial ovarian resection of extensive, bilateral, hemorrhagic ovarian cysts may be done for a young woman, thus preserving function, but for a woman 45 years of age or more this operation would not be considered advisable. Conservative procedures have their greatest application in cases of pelvic inflammatory disease, uterine fibroid tumor, adenomyoma, ovarian cyst, and endometriosis.

The most frequent pelvic infection is gonorrheal salpingitis, next is streptococcic perimetritis and cellulitis, then secondary infections by colon bacilli and tuberculous salpingitis, and, finally, actinomycosis. Prior to Simpson's time, treatment of the foregoing conditions was immediate surgical extirpation or drainage. The mortality varied from 15 to 20 per cent and the morbidity was extremely high. Through Simpson's efforts a conservative era in the treatment of pelvic infections was definitely established, and the mortality was reduced to 1 per cent. Simpson maintained that before operation was advisable, the patient should have recovered from the acute attack, which required rest in bed for a variable period, and that the temperature should remain normal for three weeks following any pelvic inflammation, after the acute attack, thereby indicating complete absorption of the inflammatory exudate.

This era of conservatism was further consolidated by the observations of Crossen, who distinguished between the clinical picture of pelvic infection due to gonococci and that due to streptococci. If the importance of these distinguishing features is recognized the lives of many women will be spared. Crossen particularly stressed the mode of infection, the anatomic situation of the infection, and the virulence of each organism, because fundamental knowledge of these was essential to clinical separation of the groups and to institution of appropriate treatment in each case. The point of importance was that gonococci affect the oviduct primarily and the ovary and pelvic peritoneum secondarily, producing a pus tube, or tubo-ovarian abscess, that usually becomes sterile within a few weeks; streptococci on the other hand, penetrate the wall of the uterus and extend into the connective tissue, producing perimetritis with fixation and tenderness of the pelvic organs. The virulence of the streptococci persists indefinitely and an abscess rarely becomes sterile.

Crossen pointed out that the distinguishing features of a chronic perimetrial mass are (1) its

*Read before the Montgomery County Medical Society, Dayton, Ohio, October 19, 1934.

Division of Surgery, The Mayo Clinic.

situation in connective tissue, usually in the broad ligament, (2) its intimate blending with the wall of the uterus, as though it were a part of it, (3) its intimate blending with the wall of the pelvis, as though it were an outgrowth from it, and (4) its hardness, often resembling a cartilaginous or bony tumor growing from the wall of the pelvis. A tubo-ovarian mass, on the other hand, was distinguished by its situation high in the pelvis, or because it became prolapsed into the culdesac and did not blend so intimately with the walls of the uterus or pelvis; also, it usually was softer. Crossen formulated the dictum, which by the way is just as sound today as it was 25 years ago, that abdominal section for a streptococcal mass in the pelvis is always dangerous, as fatal peritonitis might result, and that operation in all other cases should be delayed until the period of probable sterilization has passed, except in rare cases in which, in spite of palliative measures, life is endangered by the severity of the infection.

It is between twenty and forty years of age that physiologic activity of the reproductive organs is greatest. In this period of life treatment of disease of the female pelvis should be most conservative. It is during the same period also that the incidence of pelvic infections is the greatest. Two years ago, in my investigation of the results of the Elliott treatment in chronic pelvic infections, it was found that there is a fairly constant, small group of cases which are definitely surgical and are such from the onset; the patients, in such cases, however, can be materially benefited by application to the vagina of prolonged and sustained heat, so that the surgical procedure necessary is frequently of a reconstructive type rather than of an eliminative type, as was formerly the case.

Extensive use of heat has greatly reduced the number of patients requiring surgical treatment. Some may be completely relieved of clinical symptoms, whereas others are improved to such a degree that they may refuse to have anything done surgically and are willing to accept a small degree of disability. Recently, Dr. Randall and I reported the results of conservative treatment of 125 women with chronic pelvic infections. All cases in which this diagnosis could not be definitely established were excluded. These cases were divided into three groups, in accordance with the condition from which patients suffered: (1) gonorrheal salpingo-oophoritis, (2) chronic salpingo-oophoritis of unknown etiology, and (3) perimetritis or chronic pelvic cellulitis.

The complete program of treatment by the Elliott method produced satisfactory results in 92 cases, or 73.6 per cent of the total. Twenty-one, or 22.8 per cent, of the 92 patients received surgical treatment in addition to the application of heat; hence, 77.2 per cent of the satisfactory results may be attributed to conservative measures. These results assume greater significance when it is clearly stated that these patients are those for whom surgical treatment is most commonly advised and for whom conservative measures most often fail, and, further, that surgical interference was not necessary to return the majority to normal activity.

A potent argument against immediate pelvic surgery for gonorrheal salpingitis is that in 70 to 80 per cent of such cases the condition will subside clinically in from two to three weeks. Some patients may remain free of symptoms permanently, although they perhaps are sterile. Statistics reveal that 10 to 12 per cent of such patients may subsequently become pregnant. With our newer methods of treatment it seems likely that this figure will be increased considerably.

Secondary infections in the pelvis not infrequently result from appendicitis, although I have seen infection result from diverticulitis and perforated carcinoma of the sigmoid colon. Among young girls and women, it seems to me to be a conservative procedure to remove the appendix if there is the slightest evidence that it is acutely diseased, because it is now quite commonly believed that some cases of sterility are the result of infection originating in the appendix and spreading to the adnexa. After extensive secondary infection has taken place, great caution must be exercised in selecting the proper time for surgical treatment. The majority of fecal fistulas that occur following pelvic surgery are evidence that the original operation was performed too early, unless the pelvic abscess had previously ruptured into the rectosigmoid colon. When the abdomen is opened in such cases, everything must be done that it will ever be necessary to do, and conservatism gives way to radical surgery which, however, may be conservatism in the end.

Conservatism can rarely be exercised in cases of granulomatous infection, such as tuberculosis or actinomycosis. With the former, bilateral salpingectomy is necessary, although if the ovaries and uterus are involved, their removal is indicated. This is more likely to be true in delayed cases. An analysis of my cases of tuberculous salpingitis, in which hysterectomy seemed essential to obtain complete relief, revealed tuberculous endometritis secondary to tuberculous salpingitis in 20 per cent of cases, which is contrary to the usual teaching. Extensive tuberculosis of the cervix of a young unmarried woman was recently conservatively treated on my service by extensive cauterization. The result was excellent. Such cases are rare except when they occur secondary to tuberculosis of the uterus.

Actinomycosis of the female generative tract is very rare, and I am mentioning it because it rarely can be treated conservatively. Only thir-

teen proved cases have been reported in the United States, and four of these were from The Mayo Clinic.

Myomectomy is a surgical procedure that should be given greater consideration by those general surgeons who are not gynecologists or obstetricians. It is nothing short of a criminal act to perform hysterectomy for one or two fibroid tumors, which have not destroyed the uterus, simply because the patient has menorrhagia and dysmenorrhea; especially is this true if the patient is less than 37 years of age. The surgical risk is less than 1 per cent and the chances of relief are practically 100 per cent. H. Miller stated that his statistics indicated a 33 per cent chance of pregnancy following myomectomy. The chance of recurring fibroid tumors is variously estimated at between 3 and 5 per cent. It is incorrect, however, to perform myomectomy if the uterine musculature is seriously injured, either by the existing growths or by the operation necessary to remove them; nor is it advisable to perform myomectomy if it is necessary to remove the adnexa for tubal or ovarian disease, or if the patient is at or near the menopause unless she urgently requests it.

"Adenomyoma" and "endometrioma" are terms which are frequently used interchangeably, although not all are agreed that the growths are the same histologically. The term, adenomyoma, is usually confined to those tumors of the uterus in which the glandular structure resembles endometrium. In addition, such tumors are always surrounded by smooth muscle cells, which makes it almost impossible to enucleate the growths. Adenomyomas must be dissected from the uterine musculature. Endometriosis is the term applied by Sampson to the condition in which there is aberrant endometrium situated on the ovary, in the culdesac, uterus, round ligaments, under surface of the broad ligaments, or in inguinal regions. Both conditions are frequently associated with retro-displacement of the uterus, myoma, or inflammatory disease of the adnexa. Unfortunately, such growths occur among women between the ages of 25 and 45 years, and it is in just this period that conservatism is definitely indicated.

Since ovarian function is essential to the activity of adenomyomas and endometriomas, the principles of treatment must depend on surgical intervention, with conservation of some ovarian tissue, radical removal of both ovaries, or irradiation. Surgery is the procedure of choice, and since the disease is essentially one of young women, conservatism is desirable. Unfortunately, in many instances this cannot be done. Irradiation should be resorted to only in rare instances, such as in cases in which the rectovaginal septum and colon are intimately involved. Endometrial cysts of the ovary, if small, can be destroyed with the cautery; if they are large they can be resected. Only a very thin strip of ovarian tissue is required to carry on menstrual function. It has been variously estimated that from 50 to 95 per cent of the patients treated conservatively obtain symptomatic cures. Normal pregnancies occur among a high percentage of married women whose generative functions have been preserved.

Ovarian cysts offer an excellent field for conservative pelvic surgery, but a thorough knowledge of the pathology of these cysts is essential. It is rare to encounter malignant ovarian cysts among women less than thirty years of age. Many of the cysts of young girls that we are so quick to remove surgically will rupture spontaneously and leave the ovary intact. Some are followed by intra-abdominal bleeding, but only rarely of serious nature. If these cysts persist after repeated examinations, they usually can be easily enucleated and the ovary likewise saved. The consistency of the ovary on bimanual examination frequently leads to its identification.

Among younger women, a tender, semi-cystic tumor of the ovary may be an ovarian dermoid cyst, which always constitutes a surgical condition. Complete oophorectomy is advisable, since 1.7 per cent of all dermoid cysts are malignant, and if the growth perforates the cystic wall and becomes attached to adjacent structures the mortality is 100 per cent. Unfortunately, a large number of these cysts are bilateral, and if the woman is in the childbearing period, conservative surgery is highly desirable. This usually can be accomplished by sacrificing the ovary which is affected most and by preserving a thin strip of ovarian tissue on the opposite side. The same is true of large hemorrhagic ovarian cysts, which so frequently fill the pelvis and are attached to the intestines. Complete excision is frequently possible, with preservation of a small segment of ovarian tissue.

Finally, those of us who are interested in gynecologic surgery should always think conservatively in operating on women who are in the childbearing period, and we should give a proper trial to all conservative procedures that are used to preserve function. The late Dr. Graves stated: "Conservative surgery of the pelvis is one of the most important branches of all gynecology, in that its proper performance requires great skill, expert judgment and a thorough knowledge of pelvic pathology. Success depends, therefore, in a great measure on the individual capacity of the operator."

—OSMJ—

The Annual Meeting of the Ohio State Dental Society will be held at the Neil House, Columbus, December 4, 5 and 6.

THE SYSTOLIC MURMUR IN CLINICAL MEDICINE AND IN INURANCE EXAMINATION *

By ROY W. SCOTT, M.D., CLEVELAND, OHIO

THE difference between clinical medicine and insurance examination may be illustrated in their respective interpretations of the systolic murmur. The clinician is concerned with the mechanism of adventitious cardiac sounds. He tries to differentiate an intra and extra cardiac systolic murmur, a functional and organic murmur. He observes the associated evidences of myocardial damage in the hope of determining the individual patient's cardiac future. These questions may be of academic interest to the insurance medical director, but he has found that the most expert clinical opinion does not answer his question: what is the influence of a systolic murmur on the mortality of the group? This admittedly important problem I do not presume to answer. Its solution will not come from clinicians, but from mortality data accumulated over a period of years from large groups at various age levels. When all the facts are available, the clinician may help explain them, and in so doing he may also find it necessary to change some of his opinions, particularly regarding the prognostic significance of systolic cardiac murmurs.

The attitude of the profession toward abnormal heart sounds has changed widely at different periods since Laënnec first used a roll of paper as a stethoscope in 1816. In the interval immediately following Laënnec's discovery, physicians observed that patients dying of heart failure frequently showed murmurs during life, and the conclusion was reached that murmurs were a sign of serious heart disease.

As time went on clinical and pathological observations accumulated as well as knowledge of the heart sounds, particularly those from the different valve areas. It became evident that murmurs were associated with certain architectural deformities in the heart valves. Physicians found that their clinical conceptions of the state of certain valves were often confirmed at the post mortem table and for many years a cardiac murmur was regarded as a manifestation of valvular disease. On the other hand, some individuals exhibiting cardiac murmurs, particularly systolic murmurs, were found at post mortem to have no demonstrable change in the valvular apparatus and hence a functional murmur came to be recognized. Clinicians generally, however, were so impressed with the ominous significance of cardiac murmurs as a manifestation of a diseased heart, that a clinical differentiation between a harmless and an organic murmur was rarely made. More often the individual with an unimportant systolic murmur was managed as a case of heart disease.

This extreme view appeared to have dominated clinical teaching well up until the turn of the last century. For example, in a well known book on the heart published in 1898 we find this statement: "Of all the signs of cardiac disease murmurs are usually those most confided in". In other words, heart murmurs had come to be so intimately associated with a damaged heart in the minds of the majority of the profession, that the presence of a murmur alone was usually sufficient evidence to incriminate the heart. The time was ripe for a swing of the pendulum of thought away from such an extreme view, but instead of taking up a more nearly mid-position, in many quarters at least, the pendulum has gone to the opposite extreme in the past twenty-five years particularly with regard to the significance of systolic cardiac murmurs.

Impressed with the frequency of systolic murmurs in the sound heart of young people who were observed to have no evidence of myocardial insufficiency, and who survived a normal expectancy, some prominent clinicians recently have gone so far as to say that systolic murmurs have no significance whatever; that no one ever dies of mitral insufficiency; that the stethoscope has retarded rather than advanced our knowledge of heart disease. Such views clearly represent the opposite extreme to that held by physicians of a past generation. The truth of the matter appears to lie somewhere in the middle ground. It is from this mid-position, as it were, that I propose to consider the significance of the systolic murmur heard over the precordium.

It is not my purpose to present a detailed account of the various factors producing systolic murmurs, but the causes will be briefly discussed and certain observations bearing on the interpretation of systolic murmurs will be given here. Vibrations imparted to the walls of the heart and great vessels by the circulating blood cause audible sounds which vary in intensity with the amplitude of the vibration. In other words, the more rigid and thick the wall the less intense the sound. Vibrations of the walls of the heart and vessels of sufficient amplitude to cause murmurs occur when the fluid particles of blood no longer flow in parallel stream lines, but in tortuous paths or eddies. The motion now becomes turbulent.

The commonest cause of "turbulence" in the blood stream is an increase in velocity flow. Thus

* From the Medical Clinic of Western Reserve University at City Hospital.

** Read at the Forty-fifth Annual Meeting of the Association of Life Insurance Medical Directors of America, October 18-19, 1934.

it is, that in conditions producing an increase in the minute volume output of the heart beyond the so-called "critical velocity" a murmur may be heard. Since the greatest velocity occurs during systole, we find that the vast majority of such murmurs are systolic in time. This explains the appearance of a systolic murmur in a sound heart following some brisk exercise or in individuals with a simple tachycardia from emotional excitement. Systolic murmurs from increased minute volume output are also seen in patients with hyperthyroidism and in individuals with fever.

A second common cause of turbulent motion with eddy formation results from the passage of blood through a narrow orifice directly into a channel of greater caliber. Thus incompetent mitral valves which do not seal the orifice, permit a regurgitant stream of blood into the left auricle during ventricular systole and we hear a systolic apical murmur. Another familiar example is the basal systolic murmur caused by passage of blood from the left ventricle through a narrowed aortic orifice.

A third and less common cause of turbulence in the blood stream occurs usually in diseased hearts, in which a band or cord of tissue is so disposed as to vibrate in the blood column. This may happen in cases of rupture papillary muscles or chordae tendineae; again in instances of syphilis of the aortic valve, in which a leaflet may be ruptured and vibrate in the regurgitant stream into the left ventricle much as a sail vibrates in a breeze.

We have seen that blood flow beyond the so-called "critical velocity" may cause murmurs in normal hearts. Since the viscosity of blood is a factor in velocity (as viscosity decreases the velocity increases) we find systolic murmurs in a variety of anemic states. Here another factor may be considered, namely that of cardiac dilatation, so often associated with high grade anemias. The mitral ring, anatomically a part of the left ventricle, may be widened as the ventricle dilates and a normal mitral valve may not entirely close the orifice, or the papillary muscles relaxed by disease may permit an eversion of the mitral valve. In either case a relative mitral insufficiency results with the production of an apical systolic murmur.

In some people extraneous factors are present which modify murmurs as well as heart sounds. An increase in the anterior posterior diameter of the thorax, chronic pulmonary emphysema of the large lung variety, and obesity, all render murmurs less audible than in thin chested individuals or in children.

It is usually, although not always, possible to distinguish between an intra and extra cardiac systolic murmur. The latter are most often the so-called cardio-respiratory murmurs resulting from the movement of air in the lung tissue adjacent to the heart. Such murmurs usually possess a respiratory quality, are not widely transmitted, vary with different positions of the body and with different phases of the respiratory cycle, often disappearing with a deep inspiration.

INTERPRETATION OF SYSTOLIC MURMUR

In discussing this part of my subject I have based my remarks upon observations that have come within by own experience both clinically and at the post mortem table. This may be open to the criticism that one's personal experience is necessarily limited, that views based thereon must suffer accordingly, but I know of no better approach to the subject.

The insurance applicant presenting obvious signs and symptoms of organic heart disease with or without a systolic murmur, presents no difficulty to the insurance examiner. For example, individuals with hypertension and a systolic murmur due to a relative mitral insufficiency from dilatation of the left ventricle are not an insurance risk. The real problem, both to the physician and the insurance examiner, is the individual in whom a systolic murmur is the only apparent manifestation of present or future heart disease. This is the type of case with which we are chiefly concerned.

APICAL SYSTOLIC MURMURS

We may define this murmur heard at the apex of the heart as blowing in character, beginning at or shortly after the first heart sound, and continuing for an appreciable length of time during systole. The intensity of the murmur and the proximity of the stethoscope to the heart determine the extent to which it may be transmitted away from the apex. Loud murmurs may be accompanied by a palpable thrill. Generally speaking, the louder the murmur the farther it is transmitted. Here the question may be asked: "Is the transmission or non-transmission of the adventitious sound of any value in the diagnosis"? Is an apical systolic murmur transmitted to the left axilla, to the base of the heart, or even over the left chest posteriorly, more likely to be a manifestation of heart disease than the soft systolic blow sharply localized to the region of the apex? I think this question can be answered in the affirmative. Certainly more often than not such murmurs are associated with some form of cardiovascular disease and are due to a regurgitation of blood from ventricle to auricle through an incompetent mitral valve.

We must, of course, remember that the degree of loudness and the extent of the transmission of a murmur do not necessarily increase as the heart disease advances. For instance, a slight mitral leak attended by a vigorous ventricular contraction may produce a loud murmur. As the mitral aperature widens and the ventricle dilates the murmur may fade or entirely disappear. It is not

always possible clinically to determine the cause of the mitral leak, but the post mortem examination often tells the story. The valves may be scarred and the chordae tendineae shortened from an old inflammatory process such as rheumatism, or, in elderly people they may be more or less rigid from fibrosis and calcification. In either case they are unable to seal the mitral orifice during ventricular systole. More commonly a dilated left ventricle widens the mitral ring or displaces the papillary muscle thus shortening the chordae tendineae so that even normal valves may not close the mitral orifice.

We may now consider a group of cases in which an apical systolic murmur is the sole evidence of a scarred rheumatic mitral valve. I refer to those people who give no history of a previous rheumatic infection, who have had no clinical evidence of myocardial insufficiency, and appear healthy at the time of examination. The following brief case history is a fairly typical example.

CASE REPORT

In 1919 a boy then aged 15 years was found to have an apical systolic murmur not transmitted to the axilla. There was no history of rheumatic infection, no demonstrable enlargement of the heart fluoroscopically, and no evidence of myocardial impairment functionally. A normal cardiac response to effort was found. The murmur was regarded as insignificant and the lad allowed to carry on as a normal boy. In college he engaged in competitive athletics with no apparent difficulty. After graduation, at age 24, the apical systolic murmur still present was interpreted as a functional murmur and he was accepted as a standard insurance risk. Five years later at age 29 he developed symptoms of a low-grade generalized infection. After six weeks a splenic infarction occurred and the blood culture contained streptococcus viridans. Other signs of sub-acute bacterial endocarditis appeared and the patient died five months after the onset of the disease. At no time in the clinical course was there any evidence of myocardial insufficiency. At post mortem the heart weighed 350 grams. The mitral valve was scarred from a previous rheumatic infection, but it was not narrowed to the point of stenosis. On it and extending up over the mural endocardium of the left auricle were vegetations typical of sub-acute bacterial endocarditis.

Here then was an individual whose early rheumatic infection was so mild that it passed unnoticed. As is often the case in childhood, the heart was affected. An early mitral valvulitis underwent healing, but the resulting architectural distortion in the valves rendered them incompetent. However, the resulting organic mitral incompetency caused no apparent myocardial insufficiency. Similarly the histological changes found at post mortem were of no apparent significance. For at least fourteen years prior to the patient's death (not from heart failure but from infection) the systolic apical murmur afforded the only clue to the diagnosis of organic heart disease.

The interpretation of an apical systolic murmur in the group illustrated by the above case report is little more than the expression of a clinical opinion in the individual case, but in arriving at this opinion the informed clinician today is more influenced than his predecessors of a generation ago by certain facts concerning rheumatic heart disease. These, so far as they bear on our present problem, may be briefly summarized as follows: A definite percentage (variously estimated between 20 and 25 per cent) of people with rheumatic hearts are unaware of a previous attack of rheumatic infection. A questionable organic mitral insufficiency therefore cannot be eliminated solely on the basis of a negative history of rheumatism. A rheumatic infection occurring at that most dangerous age (8 to 16) affects the heart in a varying degree in a high percentage of cases (estimated from 75 to 85 per cent.) The valve most frequently damaged is the mitral and the only sign of this damage in some cases may be a soft systolic blow at the apex. After five or more years some damaged mitral valves go on to stenosis and such individuals usually develop evidence of progressive myocardial impairment and die of heart failure. Others remain stationary and exhibit only mitral insufficiency—certainly clinically—and the future danger in these patients is not congestive heart failure, but sub-acute bacterial endocarditis.

Some people with rheumatic mitral insufficiency, of course, escape this fatal infection and survive a normal expectancy, but it is my opinion that on the whole they are poor insurance risks. It would be interesting to know how many people particularly in the third decade of life with an apical systolic murmur, accepted as standard risks, later die of sub-acute bacterial endocarditis. It seems likely that mortality in this group may be a considerable factor in the disparity between actual and anticipated expectancy in persons with sytsolic apical murmurs.

We have seen that a diseased mitral valve due to rheumatism may in the course of several years become narrowed with the development of the clinical signs of mitral stenosis. In such cases there may be an interval of several years before the signs of stenosis appear during which the only manifestation of heart disease may be an apical systolic murmur.

Ten years ago I saw a physician then aged 28 who eight years previously at age 20 had had a mild rheumatic fever. There were no subsequent attacks and he had no symptoms referable to the heart following the initial attack. A systolic apical murmur not well transmitted to the axilla was heard, the heart was not demonstrably enlarged fluoroscopically, and the electro-cardiogram was normal. The murmur was interpreted as a functional one and he was accordingly accepted as a standard insurance risk. Five years later examination revealed the same murmur a little louder than previously. Acceleration of the heart,

however, with exercise or amyl nitrate revealed the diastolic rumble and snappy first sound of mitral stenosis. In other words, it was not until thirteen years after the initial rheumatic infection that the signs of mitral stenosis appeared and these were elicited only after acceleration of the heart. Now, eighteen years after the initial infection, auscultatory signs of mitral stenosis are heard with a palpable diastolic thrill, the heart shows a typical configuration of mitral stenosis fluoroscopically, and the physician himself, today aged 38, is quite aware of his limitations in cardiac reserve. His case is illustrative of another group of individuals with rheumatic heart disease in whom an apical systolic murmur for years may be the only manifestation of organic mitral insufficiency.

Only a few years ago a prominent American clinician and teacher, in discussing the diagnosis of mitral regurgitation said: "Physicians diagnose mitral regurgitation when they hear a loud apical systolic murmur which is extremely common in all sorts of non-cardiac disease as well as in health"; and again "a diagnosis of mitral regurgitation without stenosis is never justified". It is, of course, well known that an apical systolic murmur may be heard over a sound heart under a variety of conditions particularly in young people, but if influenced by such extreme views as those we have just quoted, the examiner will interpret many apical systolic murmurs as of no consequence, when as a matter of fact, they may signify an organic mitral insufficiency from rheumatism. As we have seen, one such group succumbs to the fatal infection usually due to the streptococcus viridans, the other after a period of years develops stenosis and dies of heart failure.

Pertinent to this discussion is the question of the age at which most people with mitral insufficiency become insurance problems. We have seen that rheumatism affects the heart most frequently between the ages of 8 and 16 so that early in the third decade of life we may expect the evidence of a damaged mitral valve to appear in the majority of cases. From this time to well within the fourth decade they may be problems in diagnosis, but their number diminishes rapidly after forty, a dangerous age for the rheumatic heart. At this time of life many are either dead or are permanent cardiac cripples; others have such clear evidence of heart disease that they no longer are an insurance problem.

In discussing age groups mention may be made here of the apical systolic murmur which appears more often in men than in women, at or beyond forty years of age. A structural defect in the mitral valve due to sclerosis may be present; more often, however, we deal with a relative incompetence of the mitral orifice from left ventricular dilatation. This condition commonly associated with hypertension is of little concern to the insurance examiner, but in people with no elevation of blood pressure an accurate estimate of the systolic murmur may be important in directing our attention to the possibility of coronary disease.

Recently I examined a fifty-two year old business executive of sedentary habits who desired to increase his insurance by a considerable amount. As late as five years ago he was accepted for a large policy. The only evidence of heart disease either subjective or objective elicited in the ordinary clinical examination was an apical systolic murmur, transmitted to the left axilla, but not to the base or to the left posteriorly. It seemed likely that this murmur had appeared sometime within the past five years as no record of it was found in previous insurance examinations. There was no elevation in the blood pressure and the accessible arteries were not unduly sclerosed. Fluoroscopically, the aorta was dense, definitely widened and the left ventricle demonstrably enlarged, a finding not elicited by percussion because of the configuration of the thorax. The electro-cardiogram afforded indisputable evidence of myocardial damage.

Not all cases of hypertensive heart disease or coronary disease with or without angina pectoris have an apical systolic murmur, but its appearance in a man beyond forty, particularly if it is known that no murmur existed previously, should make us think of organic heart disease. Not all such murmurs will be correctly evaluated, but it is safer I believe, to regard them with suspicion, at least until reliable evidence to the contrary is forthcoming.

Finally I need only mention the systolic murmur heard at the apex, but transmitted from the base. Lesions of the aortic orifice, such as aortic stenosis may cause a loud systolic murmur heard at the apex, but usually the origin of such a murmur is not difficult to determine.

SYSTOLIC MURMURS AT THE BASE OF THE HEART

We come now to a consideration of systolic murmurs heard at the base of the heart. Since the significance of these basal murmurs varies widely depending on their origin at the aortic or pulmonary area, every effort to localize them should be made. It is my opinion that aortic systolic murmurs are so often associated with organic disease in adults, that from an insurance standpoint it is dangerous to regard them in any other light. A common error is made in ascribing a systolic murmur heard over the aortic area, to transmission from the pulmonic area.

The pathological changes responsible for aortic systolic murmurs involve the root of the aorta, the aortic ring and the valve cusps. The first part of the aorta may be widened from syphilis or arteriosclerosis with or without hypertension. The vessel in this situation may be greatly distorted from sclerosis and here I may mention an interesting fact, namely that some definite re-

lation exists between longevity and sclerotic changes in the first few centimeters of the aorta. In individuals who survive the proverbial three score and ten years, the first four or five centimeters of the aorta are singularly free of arteriosclerotic changes, whereas, if this part of the vessel is seriously involved the individual does not see seventy years. It may be that some factor responsible for the localization of the sclerotic process at the root of the aorta also determines in some way the state of the coronary arteries in elderly people. Whatever the explanation, one has no difficulty in proving the relation between longevity and the state of the first part of the aorta at the post mortem table.

The aorta valve cusp may be distorted from rheumatism or some other chronic inflammatory process so as to cause an obstruction from the left ventricle into the aorta with the production of an aortic systolic murmur. Again sclerotic changes in the sinuses of Valsalva may extend to the aortic cusps which become more or less rigid, project into the lumen of the aorta during systole and cause the systolic murmur of aortic stenosis. This murmur is usually harsh and when loud is accompanied by a palpable systolic thrill. In some instances the thrill is only elicited by having the patient lean forward and expire as deeply as possible bringing the palpating hand as near as possible to the aortic valve area. The systolic murmurs originating in the aorta are usually followed by a second heart sound which is frequently not heard after murmurs due to valve stenosis.

PULMONIC SYSTOLIC MURMURS

We come now to the commonest of all heart murmurs, the systolic murmur heard over the pulmonic area. It is usually blowing in character, fairly sharply localized, does not obliterate the first heart sound and is often followed by an accentuated second heart sound. It is so common in the healthy young people during a forced expiration, particularly in the dorsal position, that under these circumstances it may be regarded as physiological. The mechanism of its production is not known, but a dilatation of the pulmonary artery from increased pressure during forced expiration, the proximity of conus to the chest wall in young people, a constriction of the vessel from change in position are all factors which may be concerned.

Less common, but much more significant is the pulmonary systolic murmur due to pathological changes in the pulmonary artery associated often with hypertrophy and dilatation of the right ventricle in instances of mitral stenosis and chronic pulmonary emphysema. Congenital heart disease, pulmonary stenosis with or without architectural defect, patent ductus arteriosus, often but not always cause a systolic murmur over the pulmonary area. In these cases the diagnosis rarely rests solely on an interpretation of the murmur. In other words, the pulmonary systolic murmur of pathological significance is so frequently accompanied by other clear evidence of disease that its interpretation should not be a serious matter to the insurance examiner.

SUMMARY AND CONCLUSION

Excepting physiological systolic murmurs originating over the pulmonic area and extra cardiac respiratory murmurs all apical and aortic systolic murmurs in adults merit consideration. The faint ones are usually but not invariably benign; louder ones are frequently associated with some type of cardio-vascular disease.

An apical systolic murmur for years may afford the only clinical evidence of a damaged rheumatic mitral valve which may go on to stenosis or become the seat of the usually fatal subacute bacterial endocarditis. Aortic systolic murmurs are more often than not a sign of organic disease. The current clinical teaching that tends to disregard the significance of all systolic cardiac murmurs is just as unsound as the older view which associated every adventitious cardiac sound with organic disease. Somewhere between these two extremes lies the truth and it is from this mid-position that I think we should attempt an evaluation of systolic murmurs.

City Hospital.

—OSMJ—

A.M.A. Exhibit Space Available

Applications are now being received for space in the Scientific Exhibit to be held in conjunction with the next Annual Session of the American Medical Association in Kansas City, May 11-15, 1936.

Requests for application blanks should be addressed to Thomas G. Hull, Director, Scientific Exhibit, American Medical Association, 535 North Dearborn St., Chicago, Illinois.

No applications will be accepted after January 27, 1936.

—OSMJ—

Dr. Serge Androp, of the medical staff of the Ohio Hospital for Epileptics, Gallipolis, has been awarded $3,000 and the first prize by the Carnegie Institute for his thesis "Probability of Commitment for a Mental Disorder, Based on the Individual's Family History". Dr. Androp won from a field of 113 physicians in the United States competing for the prize. His thesis containing 12,000 words, and submitting case histories of more than 100 families to prove his contention that mental diseases are hereditary, will be printed in book form by the Institute.

MEDICAL SERVICE PLANS AND PROPOSALS ARE ANALYZED IN SPECIAL REPORT OF A.M.A. BUREAU; PRINCIPLES TO GUIDE COUNTY MEDICAL SOCIETIES SUMMARIZED

AT THE annual session of the American Medical Association in Atlantic City in June, 1935, the Bureau of Medical Economics of the A.M.A. presented to the House of Delegates a special report, in which were listed and analyzed various plans operating or proposed for indigent and general medical care.

The report, adopted by the A.M.A. House of Delegates, emphasized the good and bad features of different plans and summarized fundamental principles to guide state and county societies in their consideration of proposed programs for distributing medical services to indigents and persons of the low-income classes.

Believing the component county medical societies of the Ohio State Medical Association and the individual members should have an opportunity to study accurate and authentic data on this serious question, *The Journal* herewith re-prints in full the Bureau's report.

Special Report, Bureau of Medical Economics, American Medical Association

IN THE report of the Reference Committee at the Special Session of the House of Delegates held in Chicago in February of this year it was suggested that the Board of Trustees request the Bureau of Medical Economics to make a further study of existing county medical society plans and to develop for presentation at this meeting of the American Medical Association model skeleton plans adapted to the needs of populations of various types.

In compliance with the expressed desire of the House of Delegates, the Bureau has examined the steps that have been taken by county medical societies to organize a more equitable distribution of medical service. While numerous proposals have been elaborated by theorists for new schemes, the only significant results in securing more and better medical care for all sections of the population have had their origin in the medical profession. Nearly 200 different experiments are being conducted or considered by county medical societies in the United States; these medical societies are trying almost every method that has been proposed for such organization of medical services. The medical profession is interested and active in providing medical care for all the people. Medical societies are not only discussing these problems but are striving earnestly to improve conditions. The medical profession has recognized its responsibility and has accepted its position of leadership in providing medical service.

The experiments are so diverse and vary so widely that not only classification but even a mere enumeration is difficult. Although it is not claimed that the list of county medical society plans, operating or proposed, is complete, the geographic spread shows the extent to which interest and efforts have developed.

The following list of state or county medical society plans operating and proposed for indigent and general medical care has been compiled from the latest available material on file in the Bureau of Medical Economics. Some plans are of such a nature that they are not easily placed in any simple classification. It has been impossible to include every county medical society plan in the United States, since many plans may have been proposed or put into operation very recently. Whenever the present status of a plan is unknown, no key is given. An exact classification can be maintained at present only by almost daily telegraphic communications.

State Medical Society Plans in Operation or Proposed

Key: O. Plan for general care operating
IO. Plan for indigent care operating
P. Proposed plan for general care
IP. Proposed plan for indigent care
(February 1935)

Alabama, Medical Association of the State of
(Three Year Plan—Birmingham)
California Medical Association
(County Mutual Hospitals,
W. B. Coffey Plan,
Mutual Health Association)
Compulsory and Voluntary Health Insurance (P)
District of Columbia (O)
Iowa State Medical Society
Michigan State Medical Society (P)
Minnesota State Medical Association (IP)
New Jersey, Medical Society of (IO)
New York, Medical Society of the State of (P)
Rhode Island Medical Society (P)
Utah State Medical Association
Washington State Medical Association (O)

County Medical Society Plans

Key: O. Plan for general care operating
IO. Plan for indigent care operating
P. Proposed plan for general care
IP. Proposed plan for indigent care
(February 1935)

California
Alameda County (O)
Fresno County (O)
Kern County
San Fernando (Los Angeles County) (O)
Riverside County (O)
San Bernardino County
San Diego County (O)
San Francisco County
Santa Clara County (P)

Florida
Duval County (P)

Georgia
Fulton County (O)

Indiana
Marion County (O)
Monroe County (P)
St. Joseph County (IP)

Iowa
Benton County (IO)
Black Hawk County (IO)
Boone County (IO)
Buchanan County (IO)
Buena Vista County (IO)
Calhoun County (IO)
Cass County (IO)
Cerro Gordo County (IO)
Clay County (IO)
Clinton County (IO)
Dallas-Guthrie County (IO)
Delaware County (IO)
Des Moines County (IP)
Dubuque County (IO)
Floyd County (IO)
Franklin County (IO)
Fremont County (IO)
Greene County (IO)
Hamilton County (IO)
Hancock-Winnebago County (IO)
Hardin County (IO)
Harrison County (IO)
Henry County (IO)
Ida County (IO)
Jasper County (IO)
Jefferson County (IO)
Johnson County (IO)
Lee County (IO)
Linn County
Louisa County (IO)
Madison County (IO)
Mahaska County (IO)
Marion County (IO)
Marshall County (IO)
Mitchell County (IO)
Monona County (IO)
Montgomery County (IO)
Muscatine County (IO)
O'Brien County (IO)
Pocahontas County (IO)
Polk County (P)
Pottawattamie County (IO)
Poweshiek County (IO)
Ringgold County (IO)
Sac County (IO)
Scott County (IO)
Shelby County (IO)
Tama County (IO)
Van Buren County (IO)
Wapello County (IP)
Washington County (IO)
Webster County (IO)
Winneshiek County (IO)
Woodbury County (IO)
Wright County (IO)

Kansas
Atchison County (IO)
Barton County (IO)
Butler County (IO)
Cherokee County (IO)
Franklin County (IO)
Meade-Seward County
Reno County (IO)
Sedgwick County (IO)
Smith County (IO)
Wilson County (P)
Wyandotte County (IP)

Kentucky
Jefferson County (O)

Louisiana
Orleans Parish

Michigan
Calhoun County (IO)
Genesee County (IP)
Kent County (P)
Muskegon County (IO)
Oakland County (IO)
Wayne County (O)

Missouri
Jackson County (IP)
St. Louis County (P)

Nebraska
Lancaster County (P)
Omaha-Douglass Co. (P)

New Jersey
Ocean County

New York
Bronx County (P)
Columbia County (O)
Dutchess County
Monroe County
Nassau County (O)
New York County (P)

Ohio
Cuyahoga County (O)
Lucas County (IO)

Oregon
Multnomah County (O)

Pennsylvania
Allegheny County (P)
Chester County
Erie County (IO)
Lehigh County (IO)
Luzerne County (IO)
Northampton County (IO)
Philadelphia County
Wyoming County (IO)

South Carolina
Charleston County

Texas
Bexar County (P)
Dallas County (P)
El Paso County (P)
Harris County (P)
Jefferson County (P)
Tarrant County (P)

Virginia
Richmond Academy of Medicine (P)

Washington
Chelan County (O)
King County (O)
Lewis County (O)
Pierce County (O)
Snohomish County (O)
Spokane County (O)
Walla Walla County (O)
Whatcom County (O)
Yakima County (O)

Wisconsin
Dane County (IO) (P)
Kenosha County
Milwaukee County (P)
Oconto County (IO)
Polk County (IO)
Rock County (P)

State or County Medical Society Plans Involving Prepayment for Hospital Costs only, in which the Medical Societies are Active in the Organization and Control

(O) In Operation (P) Proposed

California
County Mutual Hospitals (State) (P)
East Bay Mutual Hospitals, Alameda (P)
Hospital Service Plan, San Francisco (P)
Hospitalization Fund, Palo Alto (O)
Mutual Hospital Service Plan, Fresno (P)
San Diego County Hospitals, San Diego (P)

District of Columbia
Group Hospitalization, Inc., Washington (O)

Georgia
Bryan's Group Hospitalization Plan, Atlanta (P)

Kansas
Wichita Community Hospital Association, Wichita

Massachusetts
Greater Boston Hospitalization Corporation, Inc. (P)

Missouri
Kansas City Hospital Plan, Kansas City (P)

New York
Associated Hospital Service of New York (O)
Westchester, N. Y. (P)

North Carolina
Hospital Savings Association, Charlotte (State)

Virginia
Richmond Academy of Medicine, Richmond (P)

County Medical Society Plans in Which the Medical Societies Have given Approval of Arrangement for the Prepayment for Hospital Care

(O) In Operation (P) Proposed

Kentucky
Louisville Hospital Service Association (P)

Michigan
Kent County Plan (P)

Minnesota
Minneapolis Hospital Council Plan (P)

Ohio
Cleveland Hospital Service Association (O)

Tennessee
Baptist Memorial Hospital, Memphis (O)

State or County Medical Society Plans for Medical and Hospital Care in Which the Medical Societies are Active in the Organization and Control

(O) In Operation (P) Proposed

California
Los Angeles Medical and Hospital Service Plan (P)
Mutual Protective Health Association, Santa Clara (P)

Michigan
Mutual Health Services (State) (P)

Ohio
Toledo and Lucas County (P)

Rhode Island
Rhode Island (State)

Texas
Bexar County (P)
Texas Medical, Surgical and Hospitalization Association, Kerrville (P)

Wisconsin
Dane County (P)
Rock County, Beloit (P)

In addition, plans involving group hospitalization have been at least studied and some action taken by state or county medical societies in the following localities:

This list is by no means inclusive but contains only those concerning which, what is believed to be reliable information, has been received.

A. Approved of

Arkansas
Logan (D)
Sebastian (D)

Colorado
Boulder County (A)

Florida
State (D)
Orange County (D)

Georgia
State (A)
Fulton County (A)

Indiana
State (D)
Vanderburgh (D)

D. Disapproved of

New Jersey
Essex (D)

New York
State (A)

Pennsylvania
Lehigh (D)
Philadelphia (D)

Utah
State (A)

Wisconsin
Milwaukee (D)

It is not possible to make all county medical society plans conform to a single general pattern. Local conditions demand that while an equitable plan must conform to sound principles of ethics, medical and legal requirements must be adjusted

likewise to local necessity. The existing plans, operating and proposed, may be classified tentatively as follows:

A. Special Fee Schedule
   For low income groups and those temporarily unemployed

B. Medical Care for the Indigent
   Contract or agreement with proper officials of the political subdivision
   1. Specified sum paid quarterly or annually
      Examples: Marshall County, Iowa; Ringgold County, Iowa; Barton County, Kan.
   2. Special fee schedule
      Examples: Clinton County, Iowa; Waterloo County, Iowa; Franklin County, Kan.; Calhoun County, Mich.; Oakland County, Mich.; Northampton County, Pa.
   3. Per Capita
      Based on periodic adjustment of indigent load
      Example: Johnson County, Iowa

C. Minimum Guarantee to Physicians
   In communities not otherwise able to secure resident physicians
   1. Part time health officer
   2. General medical service, including care of indigent
   3. Combined curative and preventive medicine supplemented by regular medical fees

D. Voluntary Budgeting for Medical Care
   1. Post payment for medical care
      (*a*) Medical Service Bureau
      Examples: Wayne County, Mich.; District of Columbia; Utah State Medical Association; Omaha-Douglas County, Neb. (P)
      (*b*) Part pay or reduced fee
      Based on social service investigation
      Examples: Alameda County and Fresno County, Calif.
      (*c*) Central Medical Service
      Social service and patient routing
      Example: San Diego County, Calif.
   2. Prepayment for medical care
      Organized for industrial groups only or all persons below a stated annual income
      (*a*) Medical Service Bureaus. Examples: States of Washington and Utah; Fulton County, Ga.
      (*b*) Hospital Associations. Example: Oregon
      (*c*) Community Medical Service. Example: Milwaukee County, Wisconsin (P)

E. Voluntary Budgeting for Hospital Care
   1. Prepayment for hospital facilities only
      Examples: Palo Alto, Calif.; Washington, D. C.; Wichita, Kan.; Associated Hospital Service of New York (P); Cleveland, Ohio

F. Special Services or Procedures
   Cooperation with health department or other agencies
   Examples: Wayne County, Mich.; New Jersey; Pennsylvania

G. Regulation of Hospital Clinic and Dispensary Admissions and Routing of Hospital Traffic
   Examples: Cleveland; Philadelphia; Nassau County, N. Y.; Mound County, N. Y.; St. Louis

H. Industrial Group Service
   Example: Spaulding Bakeries, Binghamton, N. Y.

The statements concerning the plans, here briefly described, are taken from the latest available information on file in the Bureau of Medical Economics. Changes take place so rapidly and are so often not promptly reported that it is impossible to be certain of all the details of organization at any time.

A. *Special Fee Schedule*

Location.—New York County, N. Y. Pop. 1,867,312.

Origin and Control.—Medical Society of the County of New York.

Scope.—Maximum income for single person, $900 per year; family of two, $1,400 and $250 per each extra dependent.

Methods.—Special low fee schedule based on workmen's compensation schedule. Medical society members agree to serve patients for special fee. City to be districted. List of physicians to be maintained at each district headquarters. Consultations provided at low rates.

B. *Medical Care for the Indigent*
2. *Special Fee Schedule*

Location.—Black Hawk County, Waterloo, Iowa. Pop. 69,146.

Origin and Control.—Contract between Waterloo Medical Society and board of supervisors in operation for twenty-five years. New contract, 1932.

Scope.—Indigent and population of county institutions. Unlimited service; furnish drugs, except biologic and arsenic drugs, vaccines and narcotics. Average 900 families annually.

Methods.—Paid $3,500. Survey indicated value of work in 1932, $24,000. All money used for general society work, dues, meetings, etc.; no payments to individual practitioners. Discovered that 60 per cent of work was unnecessary. New contract (1932) provides for payment at 50 per cent minimum fee schedule of Iowa State Medical Society. Physicians divided into twelve medical units. One unit furnishes services each month. Money divided on a special monthly unit basis.

Location.—Calhoun County, Battle Creek, Mich. Pop. 87,043.

Origin and Control.—Corporation formed by members of medical and dental societies. Contract for care of indigent. Free clinics abolished.

Scope.—Indigent.

Methods.—Physicians give care and reports to social worker, who investigates.

Location.—Clinton County, Clinton, Iowa. Pop. 44,377.

Origin and Control.—County medical society contract with county board of supervisors. Trustees of county medical society appoint member of medical society as medical director on salary of $25 per month, who has general supervision of whole plan.

Scope.—Indigent. Full medical care including

specialists. Hospital care paid for at $1.50 per patient day.

Methods.—Physicians rotated except former patients may have their former physician. Fee schedule to be adjusted according to money available monthly. Overhead plus sinking fund of $50 per month deducted. Maximum for physician, $150 per month.

Location.—Northampton County (Easton, Bethlehem and Allentown, Pa.) Pop. 169,304.

Origin and Control.—Public Relations Committee, Northampton County Medical Society and Physicians' and Dentists' Business Bureau.

Scope.—Indigent and part-pay patients. Complete home and office care. All persons on county poor director's list. Acute cases limited to two weeks, ten visits, $20. Drugs furnished by physician. Chronic cases, one visit per week. Collections on pay patients.

Methods.—Free choice of physician. Authorization from county poor directors. Fee schedule. Arrangements for credit rating and extended payments. Contract plan, 1933. Cost, $9,375.00. County society, 1934. Cost, $7,110.00. Larger load in 1934.

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3. *Per Capita Basis of Pay*

Location.—Johnson County, Iowa City, Iowa. Iowa. Pop. 30,276.

Origin and Control.—County medical society and staff of Mercy Hospital. Hospital staff appoints three members as board of control to audit bills and have general supervision. Majority of members of county medical society are employed full time by University College of Medicine.

Scope.—Indigent. Complete medical care given except for venereal diseases and furnishing of biologic and certain other drugs.

Methods.—Fee schedule: $1.25 per month per "registered indigent." Social service workers prepare list of indigent and issue special authorization slips.

D. *Voluntary Budgeting for Medical Care*

1. *Postpayment for Medical Care*

Location.—San Diego County, San Diego, Calif. Pop. 209,659.

Origin and Control.—Central Clinic Committee, includes San Diego County Medical Society, Community Welfare Council, county and city health departments, school health departments, Navy Relief, two hospitals. Contract Clinic Service. Started January 1, 1933.

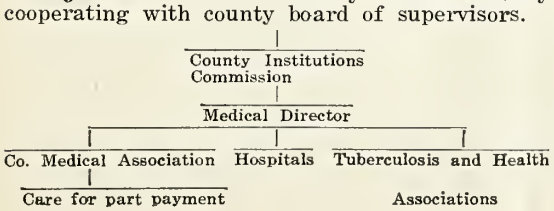
Scope.—Low wage group (indigent, part-pay and full-pay).

Methods.—Clinic Service investigates; fixes fees and terms of payment—routes patients. Does not collect medical fees.

Less than 1 per cent fail to pay.

Location.—Alameda County, Oakland, Calif. Pop. 474,883.

Origin and Control.—County medical society cooperating with county board of supervisors.



Scope.—Low wage group—indigent. Based on social service investigation which determines fee to be paid in cash when service is rendered.

Methods.—Social service investigates and reports to physicians with data for part or full pay. No collection service. Social service financed by county board of supervisors. Social service worker selects physicians from list in rotation and sets fee to be approved by physician. Obstetric fees divided equally among participating obstetricians. Reduced laboratory fees. Cooperates with Tuberculosis Association. Group hospitalization proposed.

Location.—Wayne County, Detroit, Mich. Pop. 1,888,946.

Origin and Control.—Exclusive control by county medical society. Hospitals, pharmacists, dentists and nurses cooperate with an advisory board.

Scope.—Medical care for low wage, indigent and unemployed persons by chosen physician.

Methods.—Control registration. Social service investigation. Fees fixed by physicians, hospitals, etc., after knowledge of economic state. Control collection. Cooperation with employers.

Location.—Nassau County, New York (L. I.) Pop. 303,053.

Origin and Control.—Tumor Clinic, March, 1933. Orthopedic Consultation Service, February, 1935. Public Health Hour, December, 1934. Control varies in detail but all three under ultimate control of county society. Cooperating: American Society for Control of Cancer, Tuberculosis Sanatorium, public general hospital, 195 physicians and 10 hospitals. Propose extension of general service. County Shrine Club collects and administers funds for Orthopedic Clinic.

Scope.—For indigent and pay patients. Graduate education for medical profession.

Methods.—Refer to individual physician who maintains connection and arranges fee with full-pay patients. Social service for part-pay and indigent patients. Medical society furnished executive secretary consultation privileges.

Location.—Washington, D. C. Pop. 486,869.

Origin and Control.—Central Admitting Bureau; Medical Dental Service Bureau, Inc. (not for profit); directors from medical and dental societies; cooperates with Community Chest, hospitals, pharmaceutic and other interested agencies; Arbitration Board.

Scope.—Indigent and low wage groups. Fixes fees and assists in payments.

Methods.—Physicians send patients to bureau for adjustment of terms of payment. Arranges hospital care. Directs patients. Provides social service investigation. Expenses paid by medical and dental societies and percentage on collections. Has group hospitalization plan with medical society representation.

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2. *Prepayment for Medical Care*

Location.—Pierce County, Tacoma, Wash. Pop. 163,842.

Origin and Control. — Corporation: Pierce County Industrial Medical and Surgical Service Bureau. Members of county society pay $5 admission fee. No member permitted to take competing contract. Physicians' and Dentists' Business Bureau.

Scope.—Industrial contracts. Complete medi-

cal care. Hospital care and nursing. Collection and research credit information. Installment payments.

Methods.—Prepayment industrial contracts payroll deduction. From $1 to $1.50 per month. Physician paid on fee basis. Bureau has 105 contracts; average, 40 per contract. Physicians average 90 per cent fee schedule. Employee chooses from posted panel.

Location.—King County, Seattle, Wash. Pop. 463,517. (Typical of other Washington Medical Service Bureaus.)

Origin and Control.—County medical association formed corporation—"King County Medical Service Bureau." Members forbidden to take other contracts. Must sign contracts with bureau.

Scope.—Industrial contracts on check-off system; 20,000 employees now under contract. Complete medical service, $1 to $1.50 per month per employee. Hospital and dental services. Claim payments too low for good service (*Bull. King County*, Oct. 11, 1934). Proposes group hospitalization plan for physicians engaged.

Methods.—Fee schedule. Income distributed on unit system. Physicians receive from 60 to 70 per cent of fees. Special arrangement with hospitals, druggists and ambulance service. Solicitation of contracts.

Location.—Utah State (P). Pop. 507,847.

Origin and Control.—Plan prepared by State Medical Society Committee on Medical Economics, Public Policy and Relations. Adopted by House of Delegates. "Medical Service Bureau of Utah State Medical Association, Inc." Salt Lake County Unit organized; 233 of 389 members of state association joined. Teachers oppose prepayment, prefer fees. Administered through executive office of state medical society.

Scope.—Services: Physicians', Surgeons' Laboratory. Low wage, indigent group. Taking over relief work and work relief. Collection—credit and financing.

Methods.—Contracts on prepayment basis. (See Scope.) No solicitation. No group hospitalization at present.

Location.—Fulton County, Atlanta, Ga. Pop. 318,587.

Origin and Control.—County medical society organized as corporation. Board of directors elected by members of county society.

Scope.—From $125 to $150 monthly income according to number of dependents. Single persons, $95 per month. Complete home service, excluding hospital and nursing care. Maternity and tonsillectomy special. Physicians' and Dentists' Credit Bureau for other accounts.

Methods.—$1.50 month prepayment for first member of family, $1 for second and from 50 to 75 cents for others; $1 enrollment fee. County medical society has endorsed law authorizing group hospitalization.

E. *Voluntary Budgeting for Hospital Facilities*

Location.—Cleveland Hospital Service Association, Inc., Cleveland, Ohio. Pop. 1,201,455.

Origin and Control.—Nonprofit association as agent for participating hospitals, to secure subscribers, to collect fees and to distribute and manage the funds. Academy of Medicine appoints two directors to Hospital Service Corporation. In operation since 1934.

Scope.—Approximately 5,500 subscribers; 15 hospitals participating. Subscriber must be a member of a group of 10 or more regularly employed residents of Cuyahoga County. Services: twenty-one days of hospital care; one-third discount thereafter. No professional services. Limitations: persons with certain ailments and diseases not hospitalized. Maternity cases excluded. Charges: semi-private room, $9 per year; ward, $7.20 per year.

Methods.—Director in charge of sales and administration; $6 per patient day for semiprivate room; $4.50 per patient day for ward, payable to hospitals on tenth of each month. Subscribers accepted by hospitals only on recommendation of licensed physician acceptable to hospital.

Location.—Associated Hospital Service of New York. Pop. served probably between 7,000,000 and 9,000,000.

Origin and Control.—A membership corporation not for profit to be controlled by 11 directors chosen annually by the voting membership comprising the presidents of the hospital councils of New York and Brooklyn, the 5 county medical societies, the Medical Society of the State of New York and the trustees of the United Hospital Fund. Proposed in 1934.

Scope.—Employed groups only; 140 hospitals asked to participate. Services: twenty-one days of hospital care; 25 per cent discount thereafter. No professional services. Limitations: persons with certain ailments and diseases not hospitalized. Obstetric care after ten months. If subscriber becomes unemployed services will be available for a year if payments are kept up. Charges: 90 cents a month; $10.80 per year.

Methods.—Foundations to advance $25,000 for expenses of first six months. Director and assistants to be in charge of securing subscribers—no sales staff on commission basis. $6 per patient day, more or less as funds permit, to be paid participating hospitals. $1.50 for each day in excess of the twenty-one day limit. Hospitalization only on recommendation of physician acceptable to member hospital selected by subscriber.

Location.—Group Hospitalization. Incorporated. Washington, D. C. Pop. 486,869.

Origin and Control.—Nonprofit corporation organized to operate a hospital service plan. Corporation composed of equal number from (1) district medical society, (2) participating hospitals, (3) employers, employees and general public. Board of Trustees, elected by corporation to be the governing body. Plan put in operation in 1934.

Scope.—Approximately 4,000 subscribers; 9 hospitals participating. Subscribers must be regularly employed, in sound health, under 65 years old and in approved occupation. Services: twenty-one days of hospital care; 10 per cent discount thereafter. No professional services. Limitations: persons with certain ailments and diseases not hospitalized. Obstetric care after ten months. Membership canceled after thirty days for nonpayment, or if subscriber becomes unemployed. Charges: $1 enrollment fee and $9 a year (75 cents per month). Prepayment of annual charges before hospitalization.

Methods.—Only hospitals approved by the medical society may contract to offer services. $6 per patient day to be paid hospitals as follows: $5 per patient day, payable thirty days after receipt of case and $1 or such part of $1, as funds per-

mit at end of year. Subscribers hospitalized only on recommendation of private physician who must be a member of the medical staff or acceptable to the selected hospital.

F. *Special Services—Cooperation with Health Department*

Location.—Wayne County, Detroit, Mich. (Vaughan—Geib Plan.) Also found with modifications in many other localities. Pop. 1,888,946.

Origin and Control.—Health department and county medical society in cooperation.

Scope.—Immunization for diphtheria, smallpox, etc.; physical examinations; tuberculosis and cancer campaign; some forms of school service.

Methods.—Initial organization, publicity and general administration by health departments. Fees for indigent paid by health department; others by patients. Free choice of physicians willing to cooperate. Fixed minimum fee. Education of physicians through county medical society by health department.

G. *Regulation of Hospital, Clinic and Dispensary Admissions and Routing of Hospital Traffic*

Location.—Cuyahoga County, Cleveland, Ohio. Pop. 1,201,455.

Origin and Control.—Representatives of Academy of Medicine, various hospitals and welfare organizations. Central committee issues triplicate slips to control "traffic." Academy established and controls part-pay diagnostic service.

Scope.—Control dispensary admissions. Keep patient-physician relationships previously existing, and where economic conditions permit. Hospital insurance plan in operation endorsed by Academy of Medicine. County tonsil clinics in cooperation with county board of health.

Methods.—Depends on assignment and reports. No close follow up of patients.

Location.—Monroe County, Rochester, N. Y. Pop. 423,881.

Origin and Control.—Joint committee of Medical Society of County of Monroe, Rochester Hospital Council, Baden Street Dispensary and Rochester Health Bureau.

Scope.—Hospital and dispensary care and outpatient care. Certifications of eligibility on income schedule from $12 to $32 per week, according to size of family.

Methods.—Control of hospital and outpatient care. Original reference to former physician, if known, who recommends care. Schedule of charges. Private care on reduced schedule. Hospital to provide drugs in acute cases, others to be adjusted according to ability to pay.

Location.—Philadelphia County, Philadelphia. Pop. 1,950,961.

Origin and Control.—County medical society.

Scope.—Control of dispensary admissions. Coordination of medical services.

Methods.—System of central records. Hospital authorization by physicians. Return of discharged patient to physician. Abolition of profit-making hospital optical departments. Extension of cooperation with health department and restriction of curative medicine activities of health department.

H. *Industrial Group Service*

Location.—Binghamton, N. Y. Pop. 130,005.

Origin and Control.—Started with Spaulding bakeries. Extended to three other firms. Financial control with firm. Check-off and employer contribution according to wages. Extension limited to dependents.

Scope.—Full medical service up to limit of $50 for house and office calls and $350 total per year Cash benefits to ten weeks. Limited dental care; thirty days' hospitalization.

Methods.—Completely free choice of physician. Cooperation with county medical society. Approved by New York State Medical Association. Fee schedule.

These plans involve in general the following steps:

1. Study of local medical facilities to determine the nature and extent of medical problems for which adjustment is needed.
2. Definition of persons or income groups for whom medical benefits should be provided.
3. Method of determining patient's ability to pay.
4. Amount and nature of medical service to be provided.
5. Organization and coordination of community medical services, supplemented by new units of administration when necessary.
6. Systematic movement of applicants for medical care.
7. Manner of presenting a plan to the public and method of securing members.
8. Method of making collection or receiving payments for medical care.
9. Method of remunerating physicians for their services to patients receiving benefits under the plan.
10. Administrative details.

CAREFUL PRELIMINARY STUDY NECESSARY

It is believed that a county medical society plan will add to the completeness and more even distribution of medical care in a community, the organization of such a plan should be predicated on a thorough knowledge of local facilities and requirements.

Before making any fundamental change in the organization of medical service in any locality there should be a study to determine how far the situation may be met by an adjustment of local fee schedules. This should involve consideration of the schedules already in existence in many states for the care of the indigent, for workmen's compensation service and for other special classes.

The direction of any such study should not be given to economists, sociologists and social workers without special training in medical economics. If lay research workers are utilized, it is important that their work be supervised by physicians.

It is usually better to expand existing plans than to start entirely new ones. Many county medical societies possess an organization for collection of medical fees, for care of the indigent, for regulation of clinic and hospital services, for cooperation with public health departments, for special care of the tuberculous, for the diagnosis

of cancer or for other similar purposes. It is important to know whether the medical society's committees in each of these fields have been formed merely to deal with a temporary situation or whether the organization is to function permanently before it is determined to continue or to expand such activities. The possibility of adjusting existing machinery to suit the new problems must be carefully considered. Many social problems change their quality when there is a significant change in the quantity of the factors involved.

The size of the problem which a medical society intends to attack should be definitely determined. Critics of medical society plans, especially when they are also advocates of some wholesale panacea like compulsory sickness insurance, are inclined to deprecate plans which cover only a comparatively small portion of the community. It is much easier to experiment with a small plan and expand it into a comprehensive one than to start with a big scheme involving new and cumbersome administrative machinery. Moreover, there has been a tendency to exaggerate the number of persons in the low income classes for whom any special provision is necessary. When a special plan is set up to enable members of this class to meet the economic problems concerned with medical service and no large percentage even of this low income class takes advantage of the plan, the failure of such a plan to serve large numbers may not indicate insufficient coverage so much as it does the fact that the need is not as extensive as is frequently urged.

If the study of community medical facilities is honest and comprehensive it may reveal, not infrequently, many inefficient and unnecessary medical facilities. These duplicating or unnecessary agencies should be eliminated, wherever possible, in the contemplated reorganization and better coordination of community medical services.

PERSONS FOR WHOM THE PLAN IS INTENDED

The scope of the plan should be definitely determined in the beginning. A primary division will be between the indigent and the low income classes. By low income is meant an annual income so low that payments made for medical service will reduce the amounts available for such necessities as food, housing and clothing below good health standards, which are usually placed somewhere between $900 and $1,500, varying according to local conditions.

On the other hand, an upper income limit should be fixed as a precaution against the establishment of practices not contemplated in the original plan. Failure to establish and adhere to general fundamental policies will almost inevitably result sooner or later in the inclusion in the plan of persons who have heretofore willingly supported private medical practice *without a plan.*

APPRAISAL OF ABILITY TO PAY

Proper adjustment of medical charges according to ability to pay depends on as exact knowledge as is possible of the incomes of those to be served.

A classification of illness with reference to the economic burden is another necessary preliminary step. Illnesses may be divided into "minor" and "major" or "catastrophic." Except for the indigent, the provision for medical service in minor illnesses is seldom an important economic problem. Wholesale provision for medical service for such illnesses usually results in an increase in their number. On the other hand, when expenditures in a family whose income is already close to the "comfort" or even the "subsistence" level reaches $50 or more, such a family may be forced into an economic situation destructive of the health of the entire family.

The old family doctor was a competent and friendly judge of the incomes of his patients and of the most satisfactory adjustments of payment.

Present economic complexities make it more difficult for the modern physician to obtain detailed knowledge of the individual patient's ability to pay, nevertheless, the family doctor often knows as much about the economic status of his patient as do social workers. Although the periodic investigation by the trained social worker has a definite place, such social investigations should not supplant the knowledge acquired by the family physician in his intimate contacts.

Since all plans depend on an economic classification of those they are to serve, the methods of determining economic classification are important. This will probably involve an investigation by medical social workers. It is sometimes objected that such an investigation is humiliating and harmful. Those who protest against this seem to raise no objections when subjected to a much closer investigation for the purpose of purchasing an automobile or other articles on installment, making small loans or even securing credit at most commercial establishments. Yet in none of these cases are charges adjusted to income as they are in medical services.

It is important that the field of the medical social worker should be clearly defined and separated from any part in the delivery of medical service. One of the most successful experiments in the adjustment of this relation has been conducted in Oakland County, Mich. Concerning the policy there adopted, the report of their work says:[1]

We would not go so far as to state that these two groups be entirely divorced, one from the other, as we realize full well that many problems encountered present both a social and a medical

1. Policies, Procedures and Forms of the Oakland County Emergency Welfare Relief Commission—Medical Division, Oakland and Clark Streets, Pontiac, Mich. S. S. Skelton, Administrator, R. G. Tuck, M.D., Director of the Medical Division. Compiled by B. H. Kizmiller, Office Manager, January, 1935, p. 12.

aspect. What we do think is that close cooperation be effected between these two important groups to the end that a higher degree of efficiency is gained. After all, this is a simple matter to obtain, once an understanding is reached between both professions.

Social service work as applied to medical service should always be guided by medical opinion.

Within the classification of those having incomes the analysis should not consist simply in general classifications, such as have already been described, into "subsistence," "comfort" and the like. Human beings cannot be classified for economic treatment into broad "low income" and "high income" classes any more than patients can be classified for medical treatment into broad divisions according to diseases, ages or any other characteristics. The classification should be by individuals. This is no new principle. Social workers have long accepted this principle as a fundamental one and on it have based all their technic of "case work."

AMOUNT AND NATURE OF MEDICAL SERVICE TO BE PROVIDED

The exact extent of the proposed service should be determined. Administration for collection and financing differs from that required for direct organization of any phase of medical service or for "routing" patients for clinics and hospitals and the maintenance of the personal patient-physician relation, with regulation of the scope of institutional services.

PREVENTIVE MEDICINE SHOULD BE INCLUDED

Special emphasis should be given to preventive measures. Many county medical societies are already cooperating with public health departments or private organizations in campaigns of immunization, anti-tuberculosis efforts, care for crippled children, cancer diagnosis and treatment, and so on. The relation of such cooperative agencies to any general plan should be kept in mind.

ORGANIZATION OF COMMUNITY MEDICAL FACILITIES

When a county medical society has set up the machinery necessary to a proper diagnosis of the situation as it actually exists, it is then prepared to consider the organization of the available medical facilities to be used in supplying that service. In the majority of communities there will already be found a large number and variety of institutions that have been created, partly to adjust the cost of medical service to varying incomes and partly to provide the new expensive and complex facilities demanded by modern medicine as a condition of giving good service. Among these institutions are usually a public health department, hospital with inpatient and outpatient departments, and a wide variety of clinics, dispensaries and laboratories.

There is usually a lack of any general principles of organization to be used in the adjustment of service to needs. Wherever possible, it is the function of medical societies to develop these principles and to undertake that organization for the more universal and equitable utilization of medical services for all who need them.

While all these institutions, together with a number of individual physicians, are trying to adjust medical service to income, there is little agreement as to the standards to be observed or uniformity in methods of application. Institutions established ostensibly for the indigent alone often lack of standards of indigence or accurate devices for enforcing such standards. Facilities intended originally solely for the indigent are used by those able to pay, thereby exhausting resources that would have given better service to those actually in need. Other institutions will be found exceeding their legitimate functions. They will be trying to practice medicine and to supply medical service instead of confining their efforts to the provision of facilities for that service. This, with the other conditions described, results in a general disruption of that individual personal relationship between physician and patient that is the basis of good medical service. In other words, many institutions or organizations will be attempting to produce medical service without establishing and maintaining the point of production necessary for creating such service. Such contact as exists between patient and physician will be temporary, impersonal, mechanical and adjusted to mass methods that destroy certain of the essential elements of the service. Patients will be "shopping around" from institution to institution and from physician to institution with a maximum of expense and a minimum of benefit.

SYSTEMATIC MOVEMENT OF APPLICANTS FOR MEDICAL CARE

Such a situation calls for an organization of all available medical facilities and sources of service and for systematizing the "routing" of patients in relation to physicians and institutions. Such methods have already been set up by a number of county medical societies in the United States. While these have sometimes met with resistance on the part of some of the institutions involved, once such methods have been put into operation they have met with general approval.

Any such system must start with the initiation and maintenance of a continuous contact of the patient with the physician of his choice. References of patients to hospitals, clinics, laboratories or other institutions must come from the physicians in consultation with the patients. The organization of any such system is properly the function of the county medical society. This is the only organization that touches all these institutions from the same point of view.

It must be the work of the county medical society, in cooperation with the state medical so-

ciety, and with the American Medical Association where necessary, to study the medical function of all institutions, to determine their limits in relation to the practicing physicians and to decide when and where and what medical services are to be given. This is so thoroughly an established function of organized medicine that the right to exercise it would never have been disputed if the physicians themselves and their organizations had not permitted it to lapse.

MANNER OF PRESENTING A PLAN TO THE PUBLIC

There are special dangers in the methods by which the public is induced to accept any plan. Perhaps because organizations take on something of the form of industrial and commercial patterns there has been a tendency to assume that such organizations were in some way exempt from the ethics that govern individual physicians. This position is emphatically unjustified. The Principles of Medical Ethics of the American Medical Association deal with solicitation as follows:

SEC. 4.—Solicitation of patients by physicians as individuals, or collectively in groups by whatsoever name these be called, or by institutions or organizations, whether by circular or advertisements, or by personal communications, is unprofessional. This does not prohibit ethical institutions from a legitimate advertisement of location, physical surroundings and special class—if any—of patients accommodated. It is equally unprofessional to procure patients by indirection through solicitors or agents of any kind, or by indirect advertisement, or by furnishing or inspiring newspaper or magazine comments concerning cases in which the physician has been or is concerned.

Any direct or indirect arrangement by which commissions are paid for solicitation or coercion is exercised over persons to compel patronage of any system of service in competition with private practitioners is unethical.

METHODS OF COLLECTING PAYMENT FOR MEDICAL CARE

At this stage the methods of collecting medical fees may be discussed. There is nothing inherently good or bad, from a medical point of view, in different methods of collection. Insurance, taxation, budgeting, advance financing and all other methods are nothing more than tools with which to conduct an economic transaction. They remain nothing more than this and can be discussed impartially *if they are kept strictly within the economic sphere.* The problem is to select the best method for every purpose. The chief thing to keep in mind is that *all forms of collection should be isolated from any control of service and be kept exclusively in the economic field.*

Since one of the principle objectives of any changes in medical service is improvement in the conditions of payment for such service (from the point of view of both the patient and the physician), some societies have found a collection agency operated by the society and prepared to assist in the adjustment of payment to be a good plan. Some collection plans develop financing features of assistance to both patients and physicians.

Analyses show that the class for which special provision is necessary is far smaller than most lay writers and the results of so-called "surveys" indicate. Arrangements for the indigent involve cooperation with public and private relief agencies and such an adjustment of gratuitous and underpaid care by physicians as local situations may demand. Elimination of the care of minor illness leaves only from 10 to 15 per cent of the low income class whose medical expenses each year constitute a heavy burden or so-called catastrophe. Some of these are capable of meeting even these expenses without any special arrangements. They do undertake and meet such expenditures for things far less imperatively needed than medical care for serious illnesses without requiring the establishment of any special social machinery.

The problem of many of the remainder can be solved as well as the general economic situation permits by an approximate adjustment of fees, in accordance with a full and fair investigation of resources and accompanied by arrangements for installment payments.

The exact methods used, just as in the economic and medical diagnosis, must differ with individuals. Even the problem of the entirely indigent will be less difficult after the preliminary steps of economic investigation and program making have been taken. Thorough investigation will usually reduce the number of the totally indigent. In normal times a considerable percentage of indigent and near indigent will be willingly cared for by those who have previously been their family physicians. When such a plan as is here being outlined has been in operation for some time, the number of such preliminary and permanent contacts will increase. The resulting reduction in number will also reduce the burden of gratuitous care to the point at which in many instances the physicians will gladly accept the burden as a part of their professional duty. When, as has been the case in the last three years, the burden of the medical care for the indigent is too heavy to be met in this traditional manner, collection of the necessary funds to pay at least a reduced fee should be a community responsibility.

COLLECTING FROM THE LOW INCOME GROUP

When any income exists the care for minor illnesses usually requires little more than a possible adjustment of charges.

The experience of the Wayne County, Mich. (Detroit), Medical Society has shown that the average charge to the persons receiving complete medical service, including hospitalization for

major illnesses, is less per family than the majority of proposals for sickness insurance would impose on all families sick or well.

It is possible still further to lighten the burden by the method through which the same classes are accustomed to purchase articles not ordinarily incurred in their family budgets, that is, by the installment method.

Because collection does play so important a part in the economic side of payment for medical service, many county medical societies have found it practicable to entrust the function of collection to a central office controlled by the county medical society. If this is done it is possible to coordinate and simplify all steps of the process.

METHOD OF REMUNERATING PHYSICIANS

It will sometimes be impossible in the beginning of any plan to provide for the payment of the equivalent of ordinary full fees to all the physicians engaged, even if allowance is made for a sliding scale. The amount of gratuitous service which is to be given should be clearly understood, and it should be recognized that a certain amount of such service is involved in any form of medical service. At the same time it is a fact that a high grade of medical service cannot be provided permanently unless the payment for such service is sufficient to enable physicians to maintain that standard by further education and a corresponding standard of living.

To some extent any plans will partake of the nature of contract practice. The conditions that must govern such practice were laid down in the amendment to the Principles of Medical Ethics adopted by the House of Delegates in 1934 in the following statements:

Contract practice per se is not unethical. However, certain features or conditions if present make a contract unethical, among which are: 1. When there is solicitation of patients, directly or indirectly. 2. When there is underbidding to secure the contract. 3. When the compensation is inadequate to assure good medical service. 4. When there is interference with reasonable competition in a community. 5. When free choice of a physician is prevented. 6. When the conditions of employment make it impossible to render adequate service to the patients. 7. When the contract because of any of its provisions or practical results is contrary to sound public policy.

GENERAL ADMINISTRATIVE SUGGESTIONS

No very elaborate or expensive administrative machinery is necessary, at least in the beginning of such a program as is here suggested. A central administrative office will be required to which all calls for medical service should come or be reported. This office should then refer these to the investigating agency for an economic diagnosis and to some physician for a medical diagnosis and treatment or reference, if indeed, to the proper institution. The introduction of such simple methods by county medical societies has, in some localities, either met many of the difficulties that previously existed in furnishing medical service to those needing it and who were hitherto unable to obtain it, or has opened the road to other equally short and simple steps toward progress in handling other difficulties.

After such individual economic and medical diagnoses have been made it is possible to fix a fee and determine methods of payment which will meet the situation as well as the conflicting elements of income and need will permit. That is all and indeed far more than can be said for most wholesale schemes of reorganization of medical service.

UNIFORM UNIVERSAL MODEL PLAN IMPOSSIBLE

There is no model plan which is a cure-all for the social ills any more than there is a panacea for the physical ills that affect mankind. Moreover, it will be found after careful and honest examination of the needs of some communities that a *plan* is neither necessary nor desirable. Furthermore, it may be predicted with confidence that as rapidly as economic recovery returns other communities will be added to the list not requiring any new or greatly modified methods for providing medical care.

In nearly every country having sickness insurance, local conditions have forced modifications of the general plan. Whether the "plan" is one imposed by legislation or one devised and operated on standards set voluntarily by the medical profession, a single, universal or master plan cannot possibly be devised to meet all the varying conditions throughout the United States or even different sections of individual states.

In designing and operating plans to provide medical care for the indigent and low income groups, county medical societies may well consider the dangerous, destructive and unethical tendencies which even the most carefully conceived and constructed plan may assume. Some of these may follow an incomplete or inaccurate preliminary estimate of the medical situation; some may result from the unpredictable factor of human nature; others may follow as the natural outcome of changes in the general economic conditions entirely beyond the control of the medical profession. Regardless of the causative factors, which may vary in different communities, county medical societies must be prepared to recognize and deal with complications affecting the organization of medical care under the specifications of a county plan just as their members are trained to deal with complications which often occur to change the course of the diseases which they treat. Some of these dangers and complications are:

1. The adoption and operation of a medical plan where it is unnecessary.

2. The stimulus aroused by good plans among irresponsible organizers to develop and operate imitations and counterfeits.

3. The establishment in medical practice of dangerous patterns following the adoption of undesirable types of plans.

4. The compromise of medical societies in the corporate practice of medicine or in the operation of insurance companies as a result of an insufficient study of state statutes and case law.

5. Failure in the operation of a plan, to conform to the Principles of Medical Ethics.

6. The almost inevitable transition of voluntary insurance plans into compulsory contributory sickness insurance systems operated by the state.

7. The difficulties involved in or the failure adequately to provide for complete control of medical affairs by the medical profession.

8. The "freezing" of medical fees at a point below that which is consistent with good medical service.

9. Failure to bear constantly in mind that a medical society plan is an experiment in the methods of distributing medical service and that it may have only a temporary usefulness, may need frequent or drastic modifications or may need to be discarded entirely.

10. Medical society plans must not be considered or accepted as a substitute for the regular practice of medicine as applied to the majority of people. If it is believed such plans may be useful, they should be considered merely as supplementary facilities in the distribution of medical service. They should be used only so long and in such a manner as they serve efficiently to make more easily available to low income groups a high quality of medical care.

GOOD PLANS SUBJECT TO IMITATIONS

Regardless of the sincerity of those who devise and operate a good medical plan, such a plan may only stimulate counterfeits promoted by irresponsible people. Competition between medical plans inevitably reduces the quality of the service and disturbs the public confidence.

There is danger that in the effort to attract patronage to any plan the public may be educated to the false belief that good medical care can be furnished for too low sums. Even the most enthusiastic advocates of compulsory sickness insurance have been forced to recognize that it is not possible to furnish a good medical service for less than $30 per person per year, or somewhat in excess of $100 per family per year.

UNDESIRABLE TYPE OF PLAN ESTABLISHES DANGEROUS PATTERN

There is always the grave danger of adopting an undesirable type of plan which it will be impossible to change later and which will become a pattern for wider plans in the future.

MEDICAL PROFESSION TO CONTROL ALL MEDICAL AFFAIRS

It is important that all matters concerning medical services should be controlled by organized medicine. The medical profession cannot if it wished, and it certainly has no such wish, avoid the duties and responsibility for such control and leadership. It therefore certainly has the right to insist on exercising the corresponding direction of any activities concerning medical service.

Legal advice is essential on all steps that may involve general or individual responsibility. This is especially true when some organization separate from the county medical society is set up.

FREEDOM OF CHOICE OF PHYSICIAN IS ESSENTIAL

The principle of free choice of physician is one that has been universally endorsed by the medical professions of all countries and proved by experience to be essential to good service. Any financial or other limits on admission to practice should not be of a nature to disbar any member of the county medical society who may desire to give service. Success depends on obtaining the cooperation of a large percentage of the membership. Any plan which divides a county medical society may do more harm than good.

SLIDING FEE SCALE

Essentially the task before the medical profession involves the old problem of furnishing one grade of medical service to all classes, some of which have incomes too low to permit them to pay the cost of such services. This problem is as old as the medical profession. The only solution that has ever been suggested is the sliding fee scale. This statement may be challenged, just as that method has been denounced, but an examination of proposed solutions provides the proof of the statement.

The principle of payment for medical service by insurance is always made on this principle. Sometimes this goes into detailed adjustment by making the collection a percentage of income. If collections are restricted to certain income limits, this is claimed to deliver to the lower income classes a service equal to that for which the excluded higher income classes must pay a larger price. The practical result is often to give the classes included in the insurance scheme a poorer service and at a higher price. It is difficult to collect sufficient payments from the underpaid classes to permit the maintenance of a high grade of service, because of the cost of administration and the method of distribution. Lay valuation, domination and direction of this service further injure its quality.

Even complete state medicine, unless all incomes have first been leveled to a common denominator, contains the principle of the graduated price. Taxation will always dstribute the burden in some degree proportionate to differ-

ences in incomes. While unequal incomes exist at the same time as equal needs, all methods existing or proposed for furnishing medical service must grade the cost according to income.

TRUE VOLUNTARY MEDICAL CHARITY

Idealism is an essential part of medical service. A destruction of the motives of public interest and willingness to serve the unfortunate, which has always accompanied and been one of the chief glories of the medical profession, will strike at one of the most important elements in the giving of that service.

Regardless of whether or not a plan to make medical service more easily available in a community is thought advisable, it is believed that the medical profession will never surrender or renounce that age-old privilege of relieving the suffering of those who are unable to pay.

SUDDEN AND DRASTIC CHANGES UNDESIRABLE

Since solutions of social questions and panaceas for economic evils are for the most part wishful thinking, which, when an attempt is made to apply them in practical life, give disappointing results, the question arises as to where progress is most easily possible and is likely to be most promising of results. That progress will be gradual—one step at a time. There is no other kind of sane progress—no sudden jumps, and least of all in social changes. Institutions, traditions and the human beings that are products of thousands of years of gradual evolution are stubbornly resistant to change. This is no less a truism than the one that says that the only constant thing is constant change. Another truism usually forgotten is that when going anywhere one must start from where one is. Whatever changes take place will consist primarily of new arrangements of things now existing. Finally, to this collection of neglected truism can be added the fact that one cannot successfully transplant from another country institutions bred of different social heredity and developed in a wholly different environment.

It is necessary constantly to make clear and to emphasize that the basic problem of medical economics is one of adjusting the relations of two systems of economics in the same society. One of these, that based on the production, distribution and consumption of the vast mass of material commodities, rests on technologic mass production. Its products are subject to valuation by demand and supply in the bargaining of the market. The operation of this system has brought about a wide variation in incomes. It has also created a social solidarity in which there are many health problems common to the whole body of the people.

Medical service is produced under quite different conditions. It is not dependent on technical evolution; mass production is not possible; value is not fixed by the conflict of the buyers and sellers in the market, but by professional standards and discipline, supplemented by legislation embodying those standards.

The medical profession, in its professional associations, is the only possible body that can organize the supply and distribution of that service without harmful effects on, and possible destruction of, that service itself. This principle has already been accepted in all countries by the establishment of systems of licensure, medical education and other standards of medical service set up by the profession to protect the public. It is recognized in the decisions of courts restricting the furnishing of such service to those who have met professional standards and in the rulings that expert evidence concerning medical matters can be given only by those who have met such standards.

This situation is not changed in any essential way by the fact that the progress of medical science and art has caused the creation of many subsidiary organizations and much mechanical and scientific equipment. All these things center around and are dependent on the medical profession. The "point of production" of medical service is where the individual physician meets the individual patient. Hospitals are built and conducted to create the best possible environment for that contact. Laboratories are maintained to improve the conditions of that contact. Nurses, social workers and others concerned have a similar function.

It therefore follows that in any plan to improve the adjustment of the relations between these two economies the medical profession must retain a central position in all that concerns the valuation and delivery of medical service. There is another practical reason why this must be true. While each of the other elements involved plays an important part, the common element without which no one nor all of them can function in the delivery of service is the physician. Just as he is the central and the essential element at the point of production of medical service, so he must exercise a position of leadership and control in any reorganization of the methods of giving that service. The profession needs, and will always welcome, the cooperation and advice of all elements affected in health problems, but just as the individual physician must constantly assume the tremendous responsibility of decisions that involve life and death with individual patients, so the profession as a whole must assume the leadership and responsibility in the organization of medical service in the community.

PREVIOUS ACTIONS OF THE HOUSE OF DELEGATES PERTAINING TO COUNTY MEDICAL PLANS

The House of Delegates, at the Eighty-Fifth Annual Session held at Cleveland in 1934, adopted the following principles to be followed by all constituent bodies of the American Medical Associa-

tion as bases for the conduct of any social experiments that may be contemplated by them:

First: All features of medical service in any method of medical practice should be under the control of the medical profession. No other body or individual is legally or educationally equipped to exercise such control.

Second: No third party must be permitted to come between the patient and his physician in any medical relation. All responsibility for the character of medical service must be borne by the profession.

Third: Patients must have absolute freedom to choose a legally qualified doctor of medicine who will serve them from among all those qualified to practice and who are willing to give service.

Fourth: The method of giving the service must retain a permanent, confidential relation between the patient and a "family physician". This relation must be the fundamental and dominating feature of any system.

Fifth: All medical phases of all institutions involved in the medical service should be under professional control, it being understood that hospital service and medical service should be considered separately. These institutions are but expansions of the equipment of the physician. He is the only one whom the laws of all nations recognize as competent to use them in the delivery of service. The medical profession alone can determine the adequacy and character of such institutions. Their value depends on their operation according to medical standards.

Sixth: In whatever way the cost of medical service may be distributed, it should be paid for by the patient in accordance with his income status and in a manner that is mutually satisfactory.

Seventh: Medical service must have no connection with any cash benefits.

Eighth: Any form of medical service should include within its scope all legally qualified doctors of medicine of the locality covered by its operation who wish to give service under the conditions established.

Ninth: Systems for the relief of low income classes should be limited strictly to those below the "comfort level" standard of incomes.

Tenth: There should be no restrictions on treatment or prescribing not formulated and enforced by the organized medical profession.

The importance and usefulness of the foregoing principles were again recognized by the House of Delegates in the resolution adopted at the Special Session held February 15 and 16, 1935, which read in part as follows:

The House of Delegates of the American Medical Association reaffirms its opposition to all forms of compulsory sickness insurance whether administered by the Federal government, the governments of the individual states or by any individual industry, community or similar body. It reaffirms, also, its encouragement to local medical organizations to establish plans for the provision of adequate medical service for all of the people, adjusted to present economic conditions, by voluntary budgeting to meet the costs of illness. . . .

The Committee has studied this matter from a broad standpoint, considering many plans submitted by the Bureau of Medical Economics as well as those conveyed in resolutions from the floor of the House of Delegates. It reiterates the fact that there is no model plan which is a cure-all for the social ills any more than there is a panacea for the physical ills that affect mankind. There are now more than 150 plans for medical service undergoing study and trial in various communities in the United States. Your Bureau of Medical Economics has studied these plans and is now ready and willing to advise medical societies in the creation and operation of such plans. The plans developed by the Bureau of Medical Economics will serve the people of the community in the prevention of disease, the maintenance of health and with curative care in illness. They must at the same time meet apparent economic factors and protect the public welfare by safeguarding to the medical profession the functions of control of medical standards and the continued advancement of medical educational requirements. They must not destroy that initiative which is vital to the highest type of medical service.

In the establishment of all such plans, county medical societies must be guided by the ten fundamental principles adopted by the House of Delegates at the annual session in June, 1934. The House of Delegates would again emphasize particularly the necessity for separate provision for hospital facilities and the physician's services. Payment for medical service, whether by prepayment plans, installment purchase or so-called voluntary hospital insurance plans, must hold, as absolutely distinct, remuneration for hospital care on the one hand and the individual, personal, scientific ministrations of the physician on the other.

Your Reference Committee suggests that the Board of Trustees request the Bureau of Medical Economics to study further the plans now existing and such as may develop, with special reference to the way in which they meet the needs of their communities, to the costs of operation, to the quality of service rendered, the effects of such service on the medical profession, the applicability to rural, village, urban and industrial population, and to develop for presentation at the meeting of the American Medical Association in June model skeleton plans adapted to the needs of populations of various types.

Additional material on sickness insurance and related subjects may be found in the publications listed below:

1. A Critical Analysis of Sickness Insurance.

2. A Handbook of Sickness Insurance, State Medicine, and the Costs of Medical Care.
3. Sickness Insurance Not the Remedy.
4. Contract Practice.
5. New Forms of Medical Practice.
6. Health Insurance in England and Medical Society Plans in the United States.
7. Group Hospitalization Contracts are Insurance Contracts.
8. Prepayment Plans for Hospital Care.
9. Sickness Insurance and Sickness Costs.
10. Sickness Insurance Catechism.

All these may be obtained from the Bureau of Medical Economics, American Medical Association, 535 North Dearborn Street, Chicago, Illinois.

OBLIGATIONS AND RESPONSIBILITIES OF HOSPITAL TO ITS INTERN STAFF ARE SUMMARIZED IN RECENT ARTICLE

INTERN training is a fundamental and important part of the necessary education of the physician. Few medical school graduates are properly equipped for active medical practice without the training and experience secured through intern service.

In some states, internship is required by law and medical school graduates are required to spend many months in a hospital. In fact, most graduates enter internships whether or not required to do so.

The question frequently is raised as to whether or not hospitals are fully aware of the serious responsibility delegated to them in giving the potential physician this final degree in training for active private practice.

Some institutions have assumed a rather indifferent attitude toward their interns and are failing to give them full value for their time and work.

This situation is one which deserves careful study on the part of both the hospitals and the medical profession.

An interesting, as well as beneficial, discussion of the question was published in a recent issue of *The Modern Hospital*, entitled "What the Hospital Owes the Intern".

Excerpts from the article are as follows and should stimulate interest in and discussion of this question:

* * *

THE responsibility of the hospital to the intern is second only to its responsibility to the patient. While much improvement in the character of internships has resulted from the continued insistence of medical and surgical associations upon certain standards, the actual task of providing the required postgraduate course, with those elements that permit the intern to leave his service having received from it what he needed and wanted, still devolves almost entirely upon the individual hospital.

Let us glance for a moment at what the intern has a right to receive, and at what, only too often, he does receive from the hospital in which he spends his postgraduate year. He expects to be allowed to put into practical use the half learned or often wholly forgotten general principles in the treatment and diagnosis of disease of his undergraduate days. During the short period intervening between his final examinations and graduation, much of this didactic information has become rather hazy to him. It is probable that the physician's practice is based more upon his observations of treatment made in the hospital than upon information received during his college days.

The intern learns by observing what others do and by doing himself. He requires thorough and constant supervision during his hospital days, but rarely receives it. During the all too hurried visits of his chief he should and does secure much valued information relative to the treatment of the sick, yet much of his instruction comes from a resident physician or from his own associates who are just beginning their second year of internship.

Too often this teaching is given only by word of mouth. Rarely is he given a typewritten brochure fully acquainting him with the methods in vogue in the hospital in which he is serving. He takes a clearer and more complete history during the first few months of his internship than he ever will again, in this respect he is more skilled than the chief himself or his associates, but he is not able to organize his knowledge and has had no experience upon which to draw in selecting the treatment most efficacious for the individual patient under his care. His chief, perhaps too ready to criticize, is too busy to instruct.

The intern expects a carefully considered and graded course of instruction which is fitted to his developing capabilities. In most institutions some sort of intern schedule has been adopted. Too frequently, however, such schedules smack of carelessness and lack pedagogic skill. In a classical course the freshman is not required to perform the same tasks as the senior, but as his intellectual abilities develop he is led forward until his training culminates on graduation day. Such a sound arrangement is often absent in the intern course.

The new intern on his first day in the institution is sometimes expected to perform tasks of which he is entirely incapable. He attempts the impossible when he is assigned to assist at a major operation, or perform ward dressings, or carry out minor medical surgery. It is unfair both to the intern and to the patient when a recent graduate is given full charge in a busy accident ward. It is the exception rather than the rule for a carefully considered course of instruction to be given the new intern before he is permitted or required to assume serious responsibilities. Not infrequently the young intern is informed that his duties on the first day consist of such steps as taking blood for serology, performing extensive surgical dressings, taking throat cultures or counting blood. These procedures later will be simplicity itself to the same young physician, yet on his first day or even during his first few weeks in the hospital they represent decidedly major procedures.

DO YOU EXPECT THE IMPOSSIBLE?

That hospital which does not take into full consideration the new intern's inexperience, his abject terror of being required to assume responsibility for which he is not prepared is falling far short of properly planning for a well rounded training course. The first few days of the intern's life in a hospital should be largely given over to didactic instruction and practical demonstrations of methods employed in the practice of institutional medicine. A chief resident physician and a selected group of associates or assistants on the the visiting staff may make up this faculty.

When the necessary capabilities have been acquired to enable an intern safely to assume other and greater responsibilities, then and only then should they be imposed upon him. Incidentally it may be remarked that throughout the whole intern course, this spirit of demonstration and instruction should be carried on. It is unfair to the patient as well as to the intern to permit him to attempt a blood transfusion without having been first fully instructed as to the best methods to employ. A clinic on the needling of chests and of peritoneal and pericardial cavities, at which all interns are required to be present, might well be held.

The first obligation of the hospital is to furnish good care for the sick. Efficient treatment of the sick is bound as a by-product to produce valuable training for nurses and interns. It is impossible for either of these considerations to be successfully attained without time and effort being spent in didactic instruction before the practical application of such methods is permitted.

The intern expects instruction in the art of practicing medicine. He receives little, if any, training during his collegiate course pertaining to his personal conduct in the presence of the sick. Most curriculums are too largely concerned with the frantic endeavor to prepare the young doctor for the diagnosis and treatment of disease to take into consideration that physicians who are inhumane, inconsiderate or unkind to those persons who happen to be possessed of diseased hearts or deranged livers cannot render good medical service.

MEDICAL SKILL ALONE DOESN'T BRING SUCCESS

If he does not receive the proper training in his medical college as to bedside conduct, he surely should be given the opportunity of learning about these things which, to an even greater degree than an absence or presence of unusual medical skill, will determine his success in the practice of his profession. Examples of good conduct should be set him by his chiefs. Watching them, he should learn to refrain from discussing prognosis and diagnosis in the presence of terrified patients, and he should learn the value of kindliness. He should be instructed as to the best methods of examining a female patient without embarrassment to her. He should be taught the effect of sickness upon personality and told of the importance of understanding the psychology of the members of the patient's family.

How may all of these requirements be set down in an intern's schedule? What are the practical methods for organizing a program that will begin with the performance of simple procedures, and add as it progresses to the young house officer's responsibilities until the full period of service is completed? The building of an intern schedule is not a simple task. Its nature depends upon the size of the hospital and the scope of the work performed in its departments. Nevertheless, whether there be two or twenty interns, a course of instruction must be set down in which each duty assigned to the intern is accounted for. No college could long continue without a curriculum. No resident medical service to patients can be adequate without a planned schedule covering each hour of the day's work or at least containing every type of contribution which should be made by the intern to the patient. It should be conceded then, from the start, that all hospitals training interns must have a written curriculum and must strive to adhere to it.

BROAD GENERAL EXPERIENCE ESSENTIAL

There are two usual types of intern service, that which rotates at stated periods and that which contains long assignments to one particular type of work. The former, or rotating service, is conceded by many to be the one best adapted to furnish a well balanced training for the general practitioner in medicine. The hospital intern year is not the time to train specialists. The unit schedule, which assigns the intern during six or more months to medicine or surgery, is better adapted as a foundation for specialization, but no physician should be permitted to specialize with-

out having first broad experience in all branches of medicine.

As to the length of each period and the subjects which it contains, each hospital must be a law unto itself. This is true because the amount of available experience and the number of patients in a department vary. In many states the basic intern year consists of three months' experience in medicine, surgery, obstetrics and laboratory work, respectively. There are, however, many important and necessary duties which the intern must perform that do not strictly fall into the above classification, for ambulance interns are needed, anaesthesia must be given, dispensary hours must be covered.

Because so little attention is given to the education of the intern, a clumsy schedule frequently requires his presence in several places at one time. When this happens patients must wait, chiefs become disgruntled and personal friction arises. Anaesthesia, dispensary, ambulance and accident ward duties in the small hospital are likely to be assigned to the intern along with other major obligations. As a result, the intern, legitimately employed elsewhere, is criticized for delay in answering an ambulance call, or some other summons.

An intern schedule drawn up in the manner employed in medical college curriculums where block assignments of duties are set down, is often graphically helpful. A hospital executive who fails to remember that those who wear the white uniform are human beings requiring hours for sleep, time for meals and some recreational opportunities, is likely to be unfair to the young graduate and to fail his patients.

The irascible and demanding chief who insists that the intern be at his side while he gossips with those whom he meets, forgets that while he thus squanders time a patient somewhere is without the service of his intern. This is a curious attitude on the part of some chiefs. To them the intern is something of an automaton, placed in the hospital for the particular benefit of the chiefs.

The length of periods in a rotating service depends upon the amount of material available. The number of interns required is indicated by the number of patients assigned to a particular department. In institutions of size, more than one series of from two to four-month assignments must be worked out. In the largest hospitals experience in every branch cannot be given to each intern. If all of the specialties were given the periods of assignment would necessarily be too short, for, if they were adequate, the total intern course would become too long. This problem is more or less easily solved by conducting several services, each with its subdivisions and each covering the subjects required by the licensing board of the state.

Whether or not the junior and senior system should be adopted depends upon the size and nature of the hospital. When a service is large and active, two interns or a multiple of this number may be assigned, their services so staggered that the senior will have served two or more months before the junior begins his work in a particular department. This way there is always one or more physicians who understand the scientific workings of the department. Within each department there may be subassignments. The junior intern on surgery may, in addition to his other duties, be expected to care for the laryngologic, genito-urinary or proctologic patients being treated on the service of another chief. If no staff specialists are in the hospital organization and all surgical conditions are treated by the general surgeon, the situation is simplified.

There are some general rules which apply to the building of any intern schedule. It is probably not best for the same intern to treat patients in the maternity division and also assist the general surgeon at operations on infected patients. It certainly is true that the same intern should not perform postmortem examinations and also serve in the surgical or maternity departments. It is questionable whether the intern who treats children in the pediatric department should also care for the infants in the nursery.

It is proper in a twelve-month course to divide services into two or two and one-half month periods if the local state board will permit. When this is done, even though but few interns are in the hospital, a definite time can be assigned to the dispensary, ambulance, accident ward and anesthesia services, without requiring the absence of an intern from the operating room or other department.

DISPENSARY WORK IS VALUABLE

Too much importance cannot be attached to the value of good dispensary experience. There are those who believe that the experience gained in assisting at major operations is of much less practical value to the intern than is the work which he performs in the accident ward and the dispensary. The danger of permitting the intern to arrive at a belief that surgery is simple, which sometimes follows the experience of learning the feel of the scalpel or of observing the patient recover upon whom he has operated, is that upon the completion of his course he will consider himself capable of performing major surgery.

The presence of the resident system in a hospital is probably a good plan. Here older graduates in medicine are assigned to general departments and thus supervise the interns. There are many extracurricular activities which should be scheduled in the intern course. Periodic lectures to interns, monthly intern and staff conferences,

and the holding of scientific meetings by the interns help in giving a well-rounded intern experience.

Of the greatest importance to the future of medicine is the case teaching which should emanate from the chiefs themselves. Unfortunately many men of years and experience lack the ability to teach. This is the weakest point in the training of interns the country over. It would be well if inspectorial bodies would turn their attention from the importance of the physical to the absolute necessity of insisting that staffs be educationally minded. Then and only then will graduates in medicine receive what is due them during their intern course. Until and unless this is done, laws requiring one or more years of internship are unfair and oppressive. The American Hospital Association might do well to study the type of training its institutional members give their intern staffs.

—OSMJ—

Health Hazards Confronting the Italian Army Summarized

"Unseen Allies of Haile Selassie", is the title of the following interesting article by Dr. J. A. Doull, professor of hygiene and public health, Western Reserve University, School of Medicine, which appeared in a recent issue of *The Bulletin of the Academy of Medicine* of Cleveland:

In military campaigns, casualties from infectious diseases usually far exceed those due to engines and weapons of war. This is more conspicuously true when the contested area is the tropics, and it is significant that under these circumstances the invading force, if white, is more affected. From these and other general considerations, it would seem likely that the chief enemy facing Italian arms may not be the forces of the Lion of Judah but rather certain selected battalions from the powerful arm of pathogenic microbes.

Ethiopia lies entirely within the tropics but the climate varies as between different sections. In the western and north-western portions are many elevated plateaus, from which rise mountain peaks and ranges, where cool temperatures prevail. In the deep river valleys, through which military forces must march, humid tropical heat is encountered. The eastern section, Abyssinian Somaliland, is largely a semi-desert, with water holes said to be few and far between. Winter lasts from October or November to February, is followed by a hot, dry period to about the middle of June when the rains commence.

In the wild state, animals which survive eventually must reach an equilibrium with other forms of competitive life. Likewise, in countries in which little public health work has been attempted, natives acquire resistance to certain indigenous infections. Little is known of the extent to which specific diseases prevail in Ethopia, since no reports are submitted either to the League of Nations or to the Office International d'Hygiene publique but it is certain that malaria and various intestinal diseases are highly prevalent. These take their toll, it is true, but chiefly in infancy or quite early in life. The survivors are, to a large extent, immune.

The Italian army, during and since the world war has built up a fine medical corps. The veteran Castellani, now in his 59th year, is stated to be in charge of sanitation in the present campaign. All troops are vaccnated against smallpox. They also receive antityphoid inoculations before leaving Italy, and, according to newspaper reports, are given cholera vaccine; the value of the former is generally admitted, that of the latter is in considerable doubt.

A disease against which inoculations do not prevail, and which, as Osler expresses it, "has been more destructive to armies than powder and shot," is bacillary dysentery. It was the scourge of the American Civil War; it caused thousands of casualties during the world war, particularly in the Mesopotamia and Dardenelles campaigns. Usually spread by direct contact, by flies or by food, it is most difficult to control under conditions of active service. Amebic dysentery is said to be present in Ethiopia but is never such a hazard to troops. Cholera may or may not occur.

Both benign and malignant malaria are present in Ethiopia, and, with the latter, doubtless blackwater fever. Incidence falls off with the onset of the dry season. If the campaign should continue for a year, however, the Italian sanitarians will be considered efficient, and will be fortunate, if fewer than ten per cent of the troops are attacked. Quinine prophylaxis is of dubious value and is expensive; effective screening is almost impossible in the field. When road building and other soil-moving operations are commenced, anophelines acquire many new breeding places.

Having no seaports, Ethiopia probably is free from plague. Also yellow fever apparently is unknown. Phlebotomus or sand fly fever may be present; it was much in evidence in the Near East during the world war, particularly in Mesopotamia.

Other diseases which may be encountered are typhus and relapsing fever. Skin affections such as the tineas, scabies and impetigo will be a source of much disability especially in areas where frequent bathing is impossible.

Endemic infections march with Haile Selassie and are of great importance in the defense of his country. Had Ethiopia become prosperous and well-sanitated the path of the conqueror would be easier. Thus a nation which takes advantage of modern preventive medicine may weaken itself in a subsequent struggle for independence—a discouraging thought.

—OSMJ—

Christmas Seal Sale Begun

For the 29th year Christmas Seals have been placed on sale and the sale will continue to Christmas for the purpose of raising funds with which to carry on a campaign for the prevention of tuberculosis and the care of those already stricken with it.

The sale of the Seals in Ohio is under the direction of the Ohio Public Health Association. In every county in the state some organization interested in public health will have charge of the local sales, a number of city committees also having been named in addition to the county organizations.

"SUBSCRIPTIONS EXPIRE"

Also Membership Dues

The envelope containing this issue of your *Journal* bears the admonition "Annual Subscriptions Expire With This Issue".

Postal regulations permit the subscription announcement to be carried on *The Journal* envelope, but do not permit reference to "annual dues"; hence the wording as it appears on the envelope.

However, as you know, subscription to *The Journal,* is included in your annual dues to the Ohio State Medical Association which are payable in advance.

Dues for the calendar year 1936 should be paid *now* to the secretary-treasurer of your County Medical Society or Academy of Medicine in order that the State Association's proportion of the annual dues may be transmitted by him before *January 1* to the State Headquarters office.

Annual dues in the State Association for 1936 paid and transmitted *before the first of January,* mean continuous good standing in medical organization; continuous receipt of *The Journal;* and material assistance to your state officers and committees.

BETTER BUSINESS BUREAU REPRESENTATIVE PRESENTS THE LOWDOWN ON HOW SOME COLLECTION AGENCIES OPERATE

AS POINTED out in *The Journal* many times, members of the medical profession should be extremely careful in the selection of agencies to take over the collection of old and delinquent accounts. There are many "fly-by-night" collection companies operating on a national basis, distinctly to their own advantage.

Experience shows that it will be much safer and more satisfactory for the physician to use local agencies with established reputations.

In this connection, Ohio physicians will be interested in the following article on "Collection Agencies," published in a recent issue of *The Journal of the American Medical Association* and quoting from a radio broadcast given by a representative of the Chicago Better Business Bureau:

BEST COLLECTOR IS YOURSELF

"It has been said on good authority that a creditor is his own best collector, and, in the case of debts owing to doctors, dentists and other professional men, this is undoubtedly true. However, whether you are a professional man or a merchant, it would be indeed unusual if you could personally find time to collect all your outstanding debts. The task would be almost impossible.

"The alternate followed by most business men today is to turn over to a professional collection agency the job of collecting his past due accounts. Ordinarily, this service is rendered for a fee, sometimes a flat rate, but usually on a commission or contingency basis.

"About three years ago, Chicago was overrun by a small group of crooked collection agencies, which took many thousands of dollars from the community before their activities were terminated by the State's Attorney's office. They were openly operating against the law but were enabled to collect these large sums of money through a clever trick, which might be characterized as 'collecting from the creditor'.

"The procedure was usually about as follows: You would be approached by a salesman of one of these companies, who would tell you in glowing exaggerations what unusual success his company had experienced in collecting money. You need not pay the company anything until the collections had been remitted to you and there was no necessity for you to sign any contract or other written agreement. No doubt this type of presentation would appeal to almost any business man, most of whom had large numbers of outstanding accounts three years ago.

NICE COMMISSIONS PROMISED

"You can see no objections to turning over to this man some of your accounts as a trial—and, of course, you picked out your oldest accounts and usually the ones which you had long since given up hope of ever collecting. Perhaps you smiled inwardly as you gave these accounts to the salesman, but the salesman was also smiling inwardly because he received a liberal commission for obtaining every one of your accounts. These salesmen's commissions were, in fact, so liberal that the offices of these gyp concerns were besieged

every morning by men and women anxious to work for these companies. Little did they know of the reputation and methods of doing business of these fly-by-nights—all they knew was that their friends were making substantial commissions and why shouldn't they?

"On the day following the visit of the salesman, you receive a neatly typewritten letter from the company, acknowledging receipt of your accounts and assuring you that they would receive prompt attention. The 'prompt attention' was usually forthcoming about three weeks or a month later in the form of a telephone call from the company's office. It went something like this: 'Mr. Jones, we have just located a substantial bank account in the name of one of your debtors, and we would like to "tie it up" immediately to prevent his withdrawing funds until your debt is paid. If you will advance $17.50 for legal expense, we will proceed immediately to collect your debt of $450. I will send our messenger to your office within the next few minutes to pick up your check, as no time should be lost.'

A JOKER IN THE PACK

"While somewhat bewildered, you are so astonished to learn that this particular party from whom you had been trying to collect your debt for the past several years was clever enough to conceal a bank account outside the city that you give little thought to the possibility of the entire matter being a trick to obtain your money. Neither is there much opportunity given you to reflect, because the company's messenger is in your office within a few minutes after you have hung up the receiver. You reason that if you can collect $450 by spending $17.50, that certainly is good business, so the messenger receives your check. This same procedure may be repeated once or twice more before you come to the conclusion that the company is not acting in good faith. Usually, however, the average business man will hesitate before giving the company another check until he sees the results from the first one.

"Nothing further is heard from the company and your telephone calls are greeted by the various evasions popularly known as 'buck-passing.' 'Mr. So-and-So is out of the office and will call you back' or 'he is no longer with the company because we found he was crooked. ' Personal calls at the office of the company result in nothing because you can never find any one in authority—he is always 'out.'

"When the State's Attorney's officers raided one of these fly-by-night concerns, the records of the company showed more than $1000 a day was being collected by this means. The only substantial expense of the company was commissions paid to the solicitors, for no trace of any actual collection efforts in the form of letters, garnishments, wage assignments or other legal procedure was found when the company's records were examined. The only money collected was taken from the creditors—not the debtors.

MANY OPERATING ON A SHOE STRING

"Needless to say, there are no such companies operating in Chicago at the present time. However, there are a large number of collection agencies which are today operating on what is known as a 'shoe string.' These companies are operated by individuals who might make some effort to collect your debts. When they are successful, they usually retain most of what they collect for various 'fees,' 'legal charges,' and the like. It is a rare occasion when you can obtain a statement from the agency showing the status of your accounts, and if such a statement is ever forthcoming it will probably set forth collection charges far in excess of actual collections, so that you owe the company money.

"Examination of your written agreement will disclose a confusing mass of 'ifs, and buts.' Of course, you never read the agreement before you signed it, so that you have nobody to blame but yourself. If you take the trouble to dissect the various conditions in your contract, you will undoubtedly discover that the company has protected itself in every possible legal way and the various charges levied are all within the company's rights. Obviously, such collection service is of no value to you. The high pressure methods used by such companies in collecting your debts will invariably destroy your customers' good will and render them valueless as a future source of business. At the same time, you gain absolutely nothing and your debts must eventually be written off your books as a dead loss, even though the collection agency has collected in full.

"If you must employ the services of a collector, be certain that he is reliable. Regardless of whether he is a lawyer or a member of some association of collection agencies, investigate his past record and ascertain whether he has any satisfied clients—not clients who have just recently employed his services, but those who have been dealing with him for several years. Any reliable collection agency will gladly furnish you with such references."

Smiliar warnings to the profession regarding collection and financing schemes have been issued repeatedly through *The Ohio State Medical Journal* and otherwise. In the 1932 report of the Committee on Medical Economics considerable space was devoted to this subject. (May, 1932 issue *The Journal*). Other articles on this same question were published in *The Journal* as follows: August, 1934; December, 1932; July, 1932; November, 1931; September, 1931; November, 1930; October, 1930; July, 1930; March, 1930, and October, 1929.

MEDICAL ECONOMICS--SOCIAL WELFARE--PROFESSIONAL, ORGANIZATION PROBLEMS

Radio Health Programs of A.M.A. Should Be Boosted by Physicians

The dramatized radio health program of the American Medical Association which is on the air at 5 o'clock every Tuesday afternoon over the Blue Network of the National Broadcasting Company, is being enthusiastically received by radio listeners, according to the "fan" mail which is pouring in to the A.M.A. offices from all over the country.

It is suggested that physicians call the attention of their patients to this interesting and instructive program. Also, physicians who have contacts with local newspapers should make a special effort to get paragraphs about the programs in the radio columns.

The following topics will be discussed during December:

Dec. 3 Tuberculosis—Dr. Morris Fishbein
10 Hunting Accidents—Dr. Morris Fishbein
17 Animal Diseases in Man—Dr. W. W. Bauer
24 Eat, Drink and Be Merry—Dr. W. W. Bauer
31 Pneumonia—Dr. W. W. Bauer

—OSMJ—

State-Wide Plan For Group Hospital Insurance Proposed

At a recent meeting of the Board of Trustees of the Ohio Hospital Association a program was adopted providing for the development of a state-wide plan for the periodic payment of hospitalization.

It is expected that the plan will be somewhat like that now being operated in Cleveland.

Corporations, similar to the Cleveland Hospital Service Association, will be organized in the larger counties of the state to act as agencies of the hospitals for the promotion of group hospitalization in the respective counties.

Each county medical society should see to it that the viewpoint of the medical profession is properly presented when and if the proposed plan is being considered in that county.

The nature of group hospital insurance contracts is of vital importance to the medical profession.

Here is a definite job for the public relations committees of medical societies in counties where such plans are under consideration.

Have You Paid Your 1936 State Association Membership Dues?

January 1, 1936, will mark the beginning of another year of concerted activity on the part of the State Association in the interests of the medical profession of Ohio.

In order to start off the new year auspiciously, the State Association must have its membership rolls as near the peak as possible.

Which should serve as a reminder to all members that *1936 membership dues in the State Association should be paid now to the secretary-treasurer of the local medical societies*, so that they can be transmitted to the State Headquarters Office, Columbus, on or before January 1 and assure all members of continuous good standing in medical organization.

In compliance with the Constitution and By-Laws, all members whose 1936 dues have not been received at the headquarters office by January 1 will automatically become delinquent for 1936 and remain so until their dues have been received.

This means they will be ineligible to participate in the benefits and services of the State Association.

You can assist yourself, the State Association, and incidentally the secretary-treasurer of your county medical society, if you will transmit to him *immediately* your 1936 State Association dues, and facilitate the work of the State Headquarters Office in entering thousands of names on the membership records and mailing membership cards to paid-up members.

—OSMJ—

State Association Services and Benefits Listed in Booklet

Plans have been made by the State Headquarters Office to send to each member at the time 1936 membership cards are mailed, a copy of an eight-page pamphlet entitled, "Facts Regarding Your Association".

This digest of the activities, benefits and services provided for individual physicians by the State Association has been prepared especially to refresh the memory of members relative to what the State Association does and can do for all members and for the information of new members.

It describes briefly the value and importance of continuous membership in medical organiza-

tion; a dozen or more of the more important services of the headquarters office, available to all members; and the rules and regulations governing the Medical Defense Plan.

When you receive this booklet, read it carefully and file it for reference.

If after reading it, you have any suggestions for new activities and services, send them to the Executive Secretary so they can be considered by the Council and the various committees.

—OSMJ—

"Prophets Without Honor" or Why Courtesy Should Begin at Home

For a number of years *The Bulletin of the Toledo Academy of Medicine* has set aside space each month for discussions by the director of education of the Academy.

In the November issue of the bulletin, Dr. E. W. Huffer, the educational director, presented a critical analysis of a subject that, from a medical organization viewpoint, is state-wide in importance.

It was entitled, "Prophets Without Honor", and is quoted in full as follows without comment, since no comment seems necessary:

"It is commendable that out-of-town speakers on the Academy program usually elicit a goodly turn-out of our membership. That is as it should be. It is common courtesy to honor our guests with a sizeable audience. But one cannot help regretting the paucity of attendance when our local members appear. That is not as it should be. It is disheartening, to say the least, trying to address empty chairs.

"At a recent meeting, two of our members presented subjects of unusual general interest. One dealt with observations made abroad—the other at a large American medical center. Not only were the subjects of interest, but they were handled in a most enlightening manner. Those who were absent really missed a treat, and to the discredit of us who so consistently absent ourselves from local section meetings, we often miss something.

"Having been a fairly regular attendant at Academy meetings over a period of years, I can testify that the general average of our local section meetings is high and would, if held away from home, be hailed as good. Out of a membership of about 400, it seems strange that section meetings rarely draw many more than 50 or 75 doctors. It seems a bit inappropriate to exhort men to appear on the local programs and then fail to attend them. Either we ought to abandon regular section meetings or support them with our presence. It scarcely induces a man to exert his best efforts in preparation for his appearance before the Academy if he is made to feel that his time is wasted and his efforts lost in an empty hall. Our thesis that the author or speaker gains by his preparation is defensible, but that is not adequate recompense for the work required to make an appearance before an Academy section.

"It seems patently true that a prophet is, indeed, without honor in his own country, but we cannot help wondering if this is necessarily true. If we give better attention to our local speakers we will, I am sure, be rewarded by better and better medical presentations."

—OSMJ—

The Journal to Present Series of Articles on Medical History

The State Association has been subjected to criticism—perhaps justly—because it has been somewhat negligent in the matter of providing its members with historical information about the medical profession and the practice of medicine in Ohio during the early days of the commonwealth.

Going on the theory that it is never too late to mend, *The Journal* will present in the January issue the first of a series of articles on the early history of medicine in Ohio.

This interesting collection of presentations has been assembled by Dr. Jonathan Forman, Columbus, and one will be published monthly for an indefinite period.

They have been written by physicians whose hobby is medical history and who have made every effort to present them in a way that will make them interesting as well as highly informative.

Watch for the first of this series in the January issue.

—OSMJ—

Yardstick to Be Used in Measuring the Successful Physician

Pointing out that the degree of doctor of medicine is but one of the requisites of the man who would become a good physician, and that he must answer to many things other than passing the state board examinations, an interesting editorial, captioned "Definition of a Doctor", appeared in a recent issue of the *Jackson County* (Missouri) *Medical Journal.*

The first reaction to the article may be as intimated by the writer in the concluding paragraph. Any physician who can meet the requirements cited, certainly would be a "superman".

On reflection, however, we can think of a considerable number of physicians who could be favorably measured by the "Definition of a Doctor" yardstick.

The qualities that the Kansas City editor feels

are essential to the success of a physician are well worth repeating and are passed on for introspection.

"His moral character must be far above the average, for the avenues opened up to him in the practice of his chosen profession are lined with allurements and the social pressure brought to bear upon him during lean and ever thankless years is not inconsiderable. However, he must not be a prude, for the ranks of medicine are not for reforming crusaders.

"He must be possessed of sound judgment and be able to estimate true values, for this incumbency is present in every case he undertakes to handle; and besides, medicine, as it advances, is no less free of folly and fads than any other phase of life.

"He must be ingenious, because occasions will arise from time to time when no text-book learning will apply, but he must, through his own inventiveness, work out the solution to the problem that is pressing. Pen-knife tracheotomies and kitchen-table appendectomies still exist in a hundred different forms.

"He must be versatile. Without exception, the practice of medicine takes into practical account more of every field of learning than any other occupation or profession under the sun. He must be willing and capable of shouldering responsibility.

"He must be bold and unabashed; strong enough to face the unknown, stout enough to withstand whirlwind disaster of a suddenness greater than that of tornadoes or lightning. If surgery is in his realm—and it must of necessity be at least in part in every practicing physician's realm—he must constrain himself when honestly opined to do so notwithstanding the persuasive opinions and tactics of others, and strike freely and widely when that is the action of choice.

"He must be a good sportsman, coolly calculating his odds and the stakes for which he plays. He must not be afraid to take chances when the situation demands it.

"His command of speech must be extraordinary; for people in distress cling to the words of the physician and may be easily misled by inadvertent expressions or wrongly expressed conceptions. He must know when to talk and when to remain silent.

"He must be patient and persuade others to share that patience with him. His equanimity must be undisturbed with the little set-backs that occur along the course of every critical illness. He must never be subject to panic.

"He must have implicit faith in the sound laws of nature and never look to the supernatural for an explanation of any of the things that transpire that he does not understand at the time. Neither must he depend upon divine intervention, but must always work with a sense of his own responsibility in mind.

"He must be insensible to ingratitude, he must be forgiving and charitable. When a patient whom he has served faithfully at the last criticizes his diagnosis, tells him he has done him no good, and repays his labors with insult, then returns in distress and asks for his services he must meet him kindly and without vindictiveness.

"He must be as a father—understanding, guiding, advising, admonishing, gentle but stern when the occasion demands, and ever with the interest of his fellowmen at heart in a measure at least commensurate with his own.

"A super-man? That is what his patient asks of him and it seems at times like these that is what the world expects of him. Does this concept fit into the scheme that certain governmental agencies have proposed for him?"

—OSMJ—

One Viewpoint On Selecting Annual Meeting Delegates

As food for thought, but without editorial comment or recommendation one way or the other, *The Journal* relays to the membership herewith the following paragraphs from a letter received at the State Headquarters Office from the secretary of one of the smaller component county medical societies, expressing that writer's views on the selection of a delegate by smaller county societies to the Annual Meeting of the State Association. To quote:

"During a period of some seven and one-half years which the writer has served as secretary of one of the smaller county societies of the Ohio State Medical Association, the observation has been made that the best informed man concerning the problems of the Medical Association has been the secretary of the local Societies. In more than one instance the training period for service in the Council of the State Association as well as the higher offices within the scope of the organization has been the period of service as local secretary. It has also been painfully evident during the past several years that the smaller county organizations have not been represented at the House of Delegates of the annual sessions, due to the fact that the official delegate did not attend the session. At the last meeting held in Cincinnati there were around forty county societies whose official delegates were not present. This means that many local organizations constituting almost one-half of the component societies had no voice in the official proceedings. In fact the cross section representation of rural and urban members was so poor that a referendum questionnaire is now circulating in order to decide the time of the next meeting.

"It would seem that a solution to this problem would be in selecting the local county secretary as the official delegate to the annual session. He has had contact with the State Headquarters at frequent periods during the year, is conversant with the procedure of the organization, and has followed the progress of other societies by contact with their officers. Naturally this would only apply to the smaller organizations where the conduct of the yearly schedule of meetings, programs, and if you please politics, is left almost entirely with the secretary. There are no doubt many members who would make excellent delegates if they would attend the annual state meeting; but the representation of the rural societies should never be left in doubt. This matter should have

the attention of all rural county medical societies, before the annual election of officers which usually occurs in December."

— OSMJ —

"The most encouraging aspect of national affairs in the last few weeks, to be sure, has been the awakening currents of public opinion that have pressed themselves upon Congress and produced some modification of clumsily worded, radical and well-nigh confiscatory legislation."

Promoting the Cause of the Medical Profession Each Member's Obligation

This significant statement in David Lawrence's column in the *United States News* may well be taken as a text for a reiteration of appeals to the members of the medical profession to use their individual influence to spread the physician's viewpoint on social and economic questions.

Lay reformers are working diligently, at a most propitious time, to arouse public support for their pet schemes for socializing the medical profession and other groups.

The American Medical Association and the various state associations are using every means at their command to enlighten and protect the public and the profession.

Their most powerful weapon is the influence of the physician in the community which he has continued to serve through every period of economic distress. For that sacrificial devotion to his calling, his standing is generally respected and his judgment accepted with confidence.

With the community looking to him for advice and leadership in matters affecting medical practice and public health, the physician very properly, and as the opportunity is presented, can counteract the effect of propaganda which is threatening the very existence of the practice of medicine as a profession.

Here is an opportunity for *preventive medicine.*

Whole-hearted participation in the activities of medical organizations must be supplemented by militant effort on the part of the individual physicians, in order to *prevent* the eventual capitulation of the private practitioner.

— OSMJ —

Hamilton Physician Voices Views on Ohio Taxation Situation

Under date of November 7, 1935, *The Journal* received the following letter from Dr. Mark Millikin, Hamilton, with the request that it be published:

"Editor Ohio State Medical Journal:

"In the November issue on page 900 you cite the conclusion of a committee of physicians 'and numerous other professional, business and industrial organizations,' which has considered the revenue needs of the state. That committee has recommended the re-enactment of the sales tax, the liquid fuel tax and the cigarette tax, hoping thus to obtain about $66,000,000 for Ohio.

"There is about five or six billion dollars' worth of land in Ohio. One per cent levied on that would bring to the state between 50 and 60 million dollars; two per cent would bring twice as much; three per cent three times as much and so on. This would not be a tax on consumption or production, as these taxes undoubtedly are. Under even as low a special tax as one per cent the land speculator would find his activities much curbed. Had this committee advised an additional tax on the value of land it would have done a good job.

"But the chances are, that this committee was 'sloganized' into believing that there is need of new sources of revenue; that real-estate must be relieved; that the base of taxation must be broadened; and that taxes should be paid according to ability. This last fallacy is one which might quite easily appeal to medical men, for they are about the only group of importance obtaining revenue according to their patients' ability to give it. And then real-estate, a thing made up of land and improvements thereon, which so far the realtors have not been willing to separate. They are so mindful of the little home owner that they have reduced taxes on real-estate to one per cent where formerly it was one-and-a-half per cent. This is their way of relieving real-estate. The home owner is usually too dumb to analyze their solicitude. He learns though that the sales tax, which this committee has endorsed soon takes more of his cash than did a higher tax on real estate. He may, if he studies the land question finally see that a low tax on land makes it easy to hold until there is a demand for it. He may even see that this demand enables the owner to obtain a higher price for it, and he may wonder why the owner has the legal right to pocket what the community has made and what it should collect.

"There are still people with altitudinous brows who believe that some people don't pay any taxes. For that reason they wish to broaden the base of taxation so that they may catch them in the tax net. Such folks write critical letters to the newspapers over the caption 'Taxpayer.'

"Let me inform these committee men that when Ohio had a million idle men wishing and asking for opportunity, they would have made a line shoulder to shoulder reaching from Cincinnati to Ashtabula. That line would have traversed many farms averaging 90 acres. It would have run through once prosperous villages, towns and cities. Idle men and idle land. What an incongruity. And yet it passed the diagnostic eyes of medical men. And what was their remedy? Why, to add a bigger tax burden to stricken industry; a recrudescence of homeopathy writ large.

"The doctors' acquiescence to, and endorsement of, the sales tax would likely be changed if they were annoyed with the nuisance they so blightly pass on to vendors of goods. To collect 97 cents on the dollar or to charge a patient $1.03 with the accompanying 'what-in-hells' would perhaps bring doctors to a study of the principles of taxation. Perhaps they were confounded by the arguments of the industrialists on this committee, for when did I ever hear of a group of business men trying to solve the tax problem which proposed any other remedy than trying to tax themselves rich?

"The committee says that we need no new

taxes to finance Ohio's obligations in 1936. If our legislators had the wit to levy an additional tax on land values, it could unburden depressed business to that extent. If it would go as far as it ought, then it would raise all of the revenue Ohio needs through a tax of from three to five per cent on land values.

"If *The Ohio State Medical Journal* will advocate such a tax it might create such a mental morbidity among members of The Cornstalk League that many of our impecunious physicians would have opportunity to administer to them. The latter have money, you know, for keeping their fields fallow and their hogs from farrowing.

Sincerely,

MARK MILLIKIN, M.D.,
Hamilton, Ohio."

MANY IMPROVEMENTS IN STATE WELFARE INSTITUTIONS ARE RECOMMENDED IN SHERRILL SURVEY REPORTS

MANY comments and recommendations of particular interest to physicians are included in recent reports of the Sherrill Ohio Government Survey concerning the various divisions of the State Department of Public Welfare.

Transfer of the State Hospital for Epileptics from Gallipolis to Orient, near Columbus, and of the Institution for Feeble-Minded now at Orient to Gallipolis, is one of the major steps in meeting the feeble-minded and epileptic problem of Ohio recommended by the committee.

The report pointed out that since there is only one institution for epileptics, its present location in the extreme south-eastern corner of the state is unsatisfactory.

The institution at Gallipolis was characterized as overcrowded and inadequate. It was stated that the institution at Orient is capable of expansion, and due to its location near Columbus "would give further advantages of proximity to a large medical center where research in the cure and treatment of epilepsy could be carried on".

The report said there are about 20,000 epileptics in Ohio, of whom 30 per cent or 6,000 should have hospital care and training, whereas there are only accommodations for 2,000 at Gallipolis. It was the opinion of the investigators that the other 70 per cent should have the benefit of special training, adjustment and treatment.

The commission declared that under a proper program not more than one-tenth of the 133,000 feeble-minded persons in Ohio would need institutionalization. However, it pointed out that the present capacity of institutions for the feeble-minded in Ohio is only approximately 5,000.

"It appears therefore that this state has neither sufficient institutional capacity nor a constructive and preventive non-institutional program", the report stated.

SIX-POINT PROGRAM OUTLINED

Six essentials of a state-wide constructive program for the feeble-minded, recommended were:

1. Psychiatric and child guidance clinics to prevent the institutionalization of many and supervision of those released from institutions.
2. Special local classes and local schools for feeble-minded and retarded children.
3. State institutions serving as training schools as far as inmates are capable of training.
4. Development of the colony plan for feeble-minded.
5. Control of increase of number of defectives.
6. Development of family or board home care.

The Commission urged the immediate establishment of a division of mental hygiene in the welfare department, the head of such a division to be a highly-qualified psychiatrist, selected under civil service, and enjoying the security of tenure intended by the merit system.

The number of physicians in these institutions, their compensation and housing was termed "inadequate" and there is a shortage of nurses and dentists.

In conclusion, the report said:

"These groups constitute a much greater burden on society than is necessary, and this burden will continue to increase, if they are continued to be neglected. A program which will materially reduce and bring under control this underlying problem will in the future effect savings so great that any fair estimate would sound fantastic".

INSTITUTIONS FOR THE INSANE LAUDED

The Survey reported that the eight Ohio hospitals for the insane—located at Athens, Cleveland, Columbus, Dayton, Lima, Longview, Massillon and Toledo—"are being operated, intelligently, economically and efficiently considering their serious handicap of inadequate budgets and the weakness of central administration in the Department of Welfare".

The report said the welfare institutions were favored by having "complete and faithful personnel which has served in positions of leadership and responsibility for years".

"The superintendents are all qualified physicians and psychiatrists of many years experience", the report stated, "having in most cases come up

through the ranks of the medical staffs of the hospitals to their present positions. Fortunately they have been free from the demoralizing turnover and insecurity which has characterized so many of the other Welfare Department officials who have remained subject to political appointments".

The Commission complimented the institutions for operating on so small a per capita cost; i.e., $176.29 per year per inmate as compared with $269.00 for such hospitals throughout the country, and added:

"True economy in the hospital field lies in the direction of cutting down the intake of hospitals and supplying out-patients service through clinics; of decreasing the average period of stay in the hospitals by providing prompter and more effective treatment for all hopeful cases while in the hospitals, and, of increasing the number of safe releases from hospitals which would be possible through psychiatric clinics".

PREVENTIVE MEASURES STRESSED

The report urged further development of preventive measures through a system of psychiatric and child guidance clinics; more effective treatment of hopeful cases and greater financial aid by relatives of mental patients.

Enactment of legislation requiring annual inspection and licensing of private institutions for the care of nervous and mental patients as a function of the State Welfare Department, was recommended.

The report stated that the effectiveness of the state hospitals in reducing the period of stay for many cases could be greatly improved by:

1. Increasing the size and qualifications of the medical and psychiatric staff. (Addition of 20 psychiatrists to the staff of the state hospitals at an average salary of $2600 per year, plus maintenance was recommended).
2. Increasing the number of qualified nurses and attendants.
3. Providing proper housing and training schools for physicians and nurses.
4. Employment of a more adequate number of dentists.
5. Further development of occupational therapy.
6. Better laboratory facilities.
7. Better medical libraries for hospital staffs.
8. Relief of over-crowding in the hospitals.
9. Improvement of physical facilities and equipment for treatment of hopeful cases.

The Commission concluded its report on the state hospitals for the insane with the statement that the additional yearly cost of enlarged medical and nursing staffs, child guidance clinics, nursing training schools and establishment of a Division of Hygiene would be more than offset by the savings which would result from the reduction in the population of the hospitals, due to the clinics, improved curative effectiveness of hospitals, and improved functioning of the Support Bureau.

Establishment of a dietetics and household economy division, headed by an experienced dietitian, in the State Welfare Department was urged:

"A coordinated plan should be developed for raising farm produce to meet a standard food allowance and scientifically worked out diets for institutions".

The report urged the retirement of "superannuated and inadequately trained dietitians and housekeepers, and their replacement by experienced and trained personnel in key positions", pointing out that the cost of this move would be absorbed by the savings provided by skilled supervision.

WANT BUREAU EXPANDED

Expansion of the function of the Bureau of Juvenile Research was recommended.

It was suggested that the name of this bureau be changed to "The Bureau of Examination and Research", and that it should be a part of the proposed Division of Mental Hygiene, so that its program could be properly coordinated with that of the mental and correctional institutions.

It was explained that such a bureau should undertake an intensive study of problem children; act as a clearing house for admission of children to state institutions; maintain a master file of all delinquent and defective children and all wards of the state and conduct a state-wide system of psychiatric and child guidance clinics.

CLAIM SANATORIUM INADEQUATE

Citing the need of providing adequate facilities for the Ohio State Sanatorium at Mt. Vernon, the survey reported that "the sanatorium is obsolete for proper care of tuberculosis".

"The most economical recommendation that can be made is to give the patients adequate care so that they may be cured and returned to society in a shorter space of time. It seems paradoxical that, while the beautiful surroundings are as good as could be desired, the internal set-up and staff is so hopelessly inadequate that it is a blot upon the state. There are no facilities for the care of patients who develop acute respiratory infections or any other complications. They must remain outdoors when there should be such provision for their care as one would get in a general hospital. Refrigerating patients and exposing them to the rigors of winter outdoors with no protection has long since fallen out of vogue in the treatment of tuberculosis", the report continued.

The Commission recommended revision of the legal status of the sanatorium to include more advanced cases of pulmonary tuberculosis, declaring that the sanatorium was in fact founded on a false premise in being designated for "incipient tuberculosis", building of an infirmary, containing

operating rooms and the necessary facilities for the surgical treatment of tuberculosis, for those patients who should not be exposed to the elements; segregation of children in a separate building; remodelling of receiving buildings; demolition of existing shacks, which were termed a "disgrace", and adequate and sanitary housing facilities provided; provision of proper facilities for the sterilization of bed clothes and clothing; establishment of a department of occupational therapy; raising the nursing requirements to the standards of the American Sanatorium Association and provision for proper quarters, reasonable hours and an opportunity for recreation and relaxation for nurses; and a competent consulting staff of not more than three members to assist the superintendent.

"Both the capital investments involved and the increase of operating costs would result in very large savings in terms of human lives saved, shorter average length of stay for the patients in the hospital, a smaller number of dependent families of tubercular patients, and greater control of the spread of tuberculosis", the report concluded.

PRISON MEDICAL SERVICE HIT

Criticism of the medical and hospital facilities afforded prisoners in Ohio's penal institutions was made in the report on penal institutions.

Emphasizing its contention that the rehabilitation of a prisoner often depends indirectly upon the correction of certain physical defects and the general improvement of his health, the commission observed that "strong and high walls may confine the prisoners but they cannot confine disease germs".

Terming medical and hospital care in Ohio's penal and correctional institutions "so inadequate and antiquated that they do not even approach approximate standards of a generation ago", the report recommended that a careful study be made to determine to what extent remodelling and rehabilitating can make existing hospital facilities adequate so as to obviate the erection of new hospitals at the Ohio Penitentiary and the Mansfield Reformatory.

The report called attention to the policy of the federal government "in finding it wise to furnish high grade medical service for its prisoners at the Chillicothe Federal Reformatory and in other federal prisons".

—OSMJ—

New Academy Secretary

Mr. Raymond A. Swink has been appointed executive secretary of the Academy of Medicine of Cincinnati, succeeding Miss Helen Keelor who resigned because of her duties as treasurer of the Keelor and Sites Advertising Company. Miss Keelor was executive secretary of the Cincinnati Academy for 15 years.

Laboratory Diagnosis Situation a Medical Economic Problem

"A Medical Economic Situation Regarding Laboratory Diagnosis" was the subject discussed by Dr. Thomas L. Ramsey, president of the Toledo Academy of Medicine, in a recent issue of the *Toledo Academy Bulletin.*

Dr. Ramsey's comments are on a subject of considerable importance, economically and professionally, and timely to say the least, and were in part as follows:

A study of the situation as made by the American Society of Clinical Pathologists has revealed certain practices on the part of Public Health laboratories and hospital laboratories which act to the detriment of a recognized special group of medical practitioners, men devoting their time to clinical laboratory diagnosis.

These men have taken the regular course of study and have devoted much additional study to a difficult and important branch of medicine. They have met all the legal requirements necessary to enter the practice of medicine, are active and important members of recognized medical societies and hospital staffs, and are citizens and tax-payers in their various communities.

The American Society of Clinical Pathologists concludes that the Public Health officials, in their zeal to give service to the public and to build up their own laboratory work and usefulness, have in some instances extended their scope beyond reasonable limits of actual public health work.

The Society feels that the scope of the Public Health laboratory should be limited to strictly epidemiological work and that this work should come only through public health officials and not from practitioners of medicine out of their general practice. The Public Health laboratory should confine its laboratory work to that done for purely charitable organizations and institutions.

The argument that certain communities do not have access to competent laboratory diagnosis does not seem to justify a central Public Health Laboratory performing tests of all types for all physicians and for patients well able to pay for this service. Why not send this work to their neighboring city Pathologists who are all qualified to perform such laboratory procedures?

The amount of free laboratory service done by Public Health laboratories for patients, who certainly should not be classed as indigents, is amazing. In one laboratory the number of Wassermann tests alone, per month, runs into the thousands. Why this service should be given to those who can well afford to pay is more than any one interested in Medical Economics is able to understand.

As far as the necessity for such free laboratory service is concerned—this does not exist—as no practitioner of clinical pathology would ever refuse to do his share of charity work for deserving cases.

From a tax-payers' point of view the funds used by Public Health laboratories for this charitable work is provided for by physicians as well as laymen and the Clinical Pathologist is also a tax-payer. These funds therefore are used to help diminish the income of the Clinical Pathologist and it seems no more than just that some protest be permissible.

Certain hospital laboratories, in order to help meet their expenses and to supply their staff with laboratory service, sometimes at a small fee,

have also entered the field, probably unintentionally, but in direct competition to the private laboratory of the Clinical Pathologist. This is another step in the wrong direction and not only acts as an injustice to men doing Clinical Pathology but may be a forerunner to the installation of other departments in the hospital in direct competition to men doing other kinds of medical work.

The staff physicians who take the work from their private practice to the hospital laboratories probably do not think, or realize, that the specialty of clinical laboratory and pathological diagnosis needs their support probably more than the hospital. This is not only true from a monetary standpoint but from the standpoint that the specialty of clinical pathology deserves encouragement. Without it this very valuable branch of medicine will cease to attract new workers to the field and will drive those now in it to other more lucrative branches of medical endeavor.

The clinical pathologist would be very glad to confine his work entirely to his specialty, and would become more proficient and better equipped in it, were it possible for him to do so. As matters now stand, some are forced to practice in other fields besides their own, and to the detriment of both.

There is a progressive decrease in laboratory work that is being sent to private clinical laboratories.

REASONS FOR THIS

(a) Expense of medical care. Many physicians do not use the laboratory services of private laboratories in their endeavor to keep down the cost of medical care to the patient.

(b) The use of free laboratory services extended by the state and other municipal laboratories. The amount of this work has yearly been increasing. The expense of maintaining the state and city laboratories has proportionally increased. This is a vitally important wedge toward generalized state medicine.

(c) The increasing use of hospital laboratories for outside laboratory work. This is partially to increase the profit of the hospital laboratory and partially to offer a laboratory service to the staff for their private outside cases at a reduced laboratory fee. The hospital laboratories are therefore entering into cut rate competition with the private clinical laboratories.

(d) Hospitalization of patients for diagnosis only, thereby procuring the maximum amount of laboratory work at a minimum laboratory fee.

(e) Laboratory work is being performed by assistants in doctors' offices and clinics. Some of these are not trained technicians and often have no supervision as to the efficiency of their work; even technicians of experience need some supervision in most of the more complicated laboratory procedures.

THE RESULTS

(a) Many men of experience in laboratory procedure have already left this field and taken up more profitable lines of medical endeavor.

(b) Very few, if any, young physicians are taking up laboratory work as a specialty.

(c) Hospitals throughout the country need competent, trained men in this line of work.

(d) The salaries paid are not enticing.

(e) It takes years of study to become a competent tissue diagnostician.

(f) The future of clinical pathology is at stake.

We must maintain a high standard of efficiency in laboratory procedure and it is time for the medical profession to realize these facts.

This has been discussed repeatedly with health officers and directors of the state and municipal laboratories and the same answer is always received; that as long as the physicians demand these activities it will be necessary for them to continue.

It is therefore up to the medical profession and not the laboratories. The physicians of the state should awaken to the realization that this free service to individuals well able to pay has proceeded too far and that such free service will not stop at laboratory work if it is allowed to continue.

Let us then give thought to the question:

"What is to become of scientific diagnostic procedures unless some consideration be given to Clinical Laboratory Diagnosis as a Specialty?"

— OSMJ —

37 Physicians Licensed Through Reciprocity to Practice in Ohio

Licenses through reciprocity to practice medicine and surgery in Ohio have been issued to the following by the State Medical Board:

Dr. Marion L. Ainsworth, Columbus, University of Michigan; Dr. Edward Alberts, Cincinnati, University of Nebraska; Dr. Russell K. Ameter, Bryan, University of Arkansas; Dr. Paul B. Beeson, Wooster, McGill University; Dr. Philmour M. A. Bein, Mansfield, University of Pennsylvania; Dr. Clement H. Bockoven, Phillipsburg, Illinois Medical College; Dr. Richard M. Brady, Akron, St. Louis University; Dr. James F. Busby, Newark, Johns Hopkins University; Dr. Charles O. Butner, Jr., Elyria, University of Arkansas; Dr. Albert B. Chapla, Lorain, University of Michigan; Dr. Melvin M. Christian, Oberlin, Howard University; Dr. Martin E. Conti, Youngstown, Duke University; Dr. Winfred M. Dowlin, Canton, College of Physicians and Surgeons, Columbia University; Dr. William S. Elliott, Cambridge, Queen's University; Dr. Francis W. Epstein, Toledo, Wayne University; Dr. Crawford L. Felker, Toledo, Vanderbilt University; Dr. Robert H. K. Foster, South Charleston, Rush Medical College; Dr. William L. Hann, West Unity, Hahnemann Medical College, West Unity; Dr. Charles R. Hoskins, Athens, Medical College of Virginia; Dr. Frank J. Imburgia, Cleveland, St. Louis University; Dr. Clarence C. R. Jackson, Cleveland, Jefferson Medical College; Dr. John M. Kidd, Galion, University of Pittsburgh; Dr. Julius B. Klein, Cleveland, St. Louis University; Dr. Harold H. Klinger, Akron, Vanderbilt University; Dr. James W. McGough, Steubenville, University of Louisville; Dr. Paul Merrell, Cincinnati, University of Cincinnati; Dr. Maria S. Naples, Cleveland, University of Buffalo; Dr. Calvus E. Richards, Cincinnati, Emory University; Dr. Clarence W. Sears, Youngstown, State University of Iowa; Dr. Herman I. Slate, Martins Ferry, College of Medical Evangelists; Dr. George D. C. Thompson, Gallipolis, University of Michigan; Dr. Morris Wilderom, Medina, University of Michigan; Dr. Zeno R. Ross, Cleveland, University of Michigan; Dr. Dorothy C. V. Heinz, Toledo, University of Michigan; Dr. Almeda B. Morris, Rossford, Indiana University; Dr. Subrey H. Williams, Rossford, Indiana University, and Dr. George Crile, Jr., Cleveland, Harvard University Medical School.

COUNTY SOCIETIES *and* ACADEMIES

First District

Adams County Medical Society held its regular meeting at the Hotel Hester, Manchester, October 23. At the morning session Dr. Ray Vaughen, Cedar Mills, gave a report on the recent annual meeting of the State Association, and Dr. R. C. Wenrick, Winchester, talked on "Tumors of the Lungs". At the afternoon session, Dr. C. C. Cropper, Lynchburg, discussed "My Experiences with the Append'x", and Dr. R. A. Quigley, Maysville, Ky., read a paper on "Indications for an Operative Technic of Tonsillectomy". Dr. J. G. Inman, Manchester was elected president for the ensuing year.—News Clipping.

Clinton County Medical Society met at the General Denver Hotel, Wilmington, Tuesday noon, November 5. Several case reports were presented, and general medicine topics discussed.—News Clipping.

Hamilton County—The Academy of Medicine of Cincinnati presented the following programs during November:

November 5—"Bronchoscopy in the Diagnosis of Pulmonary Diseases", by Dr. Porter P. Vinson, Rochester, Minn.

November 12—Joint Meeting with the Heart Council. "Treatment of Heart Failure", Dr. Hugo Roessler, Philadelphia, Pa.

November 19—"John Eberle—Pioneer Internist", by Dr. David Tucker.

November 26—Case Reports. "Hypoglycemia with Confusion", by Dr. Stuart Schloss; "Hypoglycemia with Amnesia", by Dr. Charles Kiely; "Air Cyst in the Abdomen and Left Thigh", by Dr. Samuel Brown; "Voluntary Proptosis of the Eye Due to Anomalous Ocular Muscles", by Dr. Donald Lyle.—Bulletin.

Second District

Champaign County Medical Society was entertained at an informal party at the home of Dr. Robert Anderson, North Lewisburg, on Wednesday evening, October 16.—News Clipping.

Greene County Medical Society met at Xenia, Thursday, November 7, with an attendance of 30 —an all-time record. The membership of the society is 39, leaving only two practicing physicians in the county who are not members.

It was reported that the Committee on Immunization of Infants had drawn up a form letter to be sent by the county society to the parents of babies who have reached the age of six months, urging vaccination against smallpox and immunzation against diphtheria. The committee was instructed to get information before the public through newspapers and schools, urging people to pay prompt attention to runny noses, sore-throats and croup.

Four members related interesting items from the Inter-State Post Graduate Assembly recently held in Detroit.

Dr. R. M. Hughey, Washington C. H., inspired the society with his personal views on a number of intimate questions confronting the medical profession. Particularly noteworthy was his statement that the primary business of the medical profession is not to safeguard the income of physicians, but consists solely and eternally in furthering the welfare of the public.

The following officers were elected for the ensuing year: Dr. Marshall M. Best, president; Dr. T. H. Winans, vice-president; Dr. W. T. Ungard, secretary-treasurer; Dr. H. C. Messenger, delegate; Dr. C. G. McPherson, alternate; Dr. Paul D. Espey, legislative committeeman; members of the Board of Censors—Dr. George Davis, 1936-37-38; Dr. A. C. Messenger, 1936; Dr. C. E. Ream, 1936-37.—R. R. McClellan, M.D., Secretary.

Miami County Medical Society met at the Stouder Hospital, Troy, Friday afternoon, November 8. A motion picture—"Cholecystectomy", was presented and Dr. Robert D. Spencer, Piqua, read a paper on "Recent Developments in the Roentgen Ray Diagnosis of Biliary Diseases".—G. A. Woodhouse, M.D., Secretary.

Montgomery County Medical Society was addressed by Dr. E. C. Fischbein on the subject "Modern Conceptions of the Neuroses" at a meeting held Friday evening, November 1.

Dr. J. H. Warvel, Indianapolis, spoke on "The Management of Diabetes" at a meeting of the society held Friday evening, November 15.—Bulletin.

Third District

Auglaize County Medical Society met at the courthouse Wapakoneta, Thursday evening, October 31. Dr. Roy D. Arn, Dayton, gave an address on "Relief of Pain by Moderate Neuro-Surgical Measures".—Chas. C. Berlin, M.D., Secretary.

Hardin County Medical Society held its monthly session at the Kenton Cafe, Thursday evening, October 17. Dr. Frank C. Anderson, superintendent of the Ohio State Sanitarium at Mt. Vernon, spoke on "Early Symptoms, Diagnosis, and Prevention of Tuberculosis".—News Clipping.

Marion County—Marion Academy of Medicine met at the City Hospital, Marion, November 5.

Dr. Edward J. McCague, department of urology, Mercy Hospital, Pittsburgh, Pa., presented a program on "Urological Problems", using clinical material and *X*-ray plates in his discussion.—News Clipping.

Fourth District

Defiance County Medical Society met at the Definance Hospital, Tuesday, October 22. Dr. W. A. Neill, Toledo, gave an interesting talk on "Tumors of the Breast".—H. B. Wideman, M.D., Secretary.

Lucas County—The Toledo Academy of Medicine held a joint meeting with the Toledo Dental Society at the Chamber of Commerce Auditorium, Friday evening, November 1. Dr. Edward C. Rosenow, director of the Division of Bacteriology, Mayo Clinic, Rochester, Minn., discussed "Focal Infection and Elective Localization of Bacteria".

The following section meetings were held during November:

November 15—Medical Section. Dr. E. A. Sharp, Detroit, discussed "Recent Advances in Therapy".

November 22—Surgical Section. Dr. Norris W. Gillette spoke on "Hyperparathyroidism and Osteomalacia". Drs. J. T. Murphy, E. P. Gillette and A. H. Schade were the discussants.

November 29—Eye, Ear, Nose and Throat Section. Dr. R. E. Boice discussed "Vitreous Opacities, Treated with *X*-ray"; Dr. J. L. Roberts spoke on "Tumors of the Eye, including Lymphosarcoma", and Dr. L. R. Effler, described "A Flight to Yucatan".—Bulletin.

Sandusky County Medical Society met at the City Hall, Fremont, Thursday evening, October 31. Following scientific addresses by Dr. L. A. Levison and Dr. Leonard Nippe, Toledo, the society discussed the problem of medical care of the indigent.—News Clipping.

Wood County Medical Society held its monthly dinner meeting at the Women's Club, Bowling Green, Thursday evening, October 17. "Treatment of Disease, Deformities and Impaired Function of Physical Therapy" was the topic discussed by Dr. E. M. Collier, Dr. B. J. Hein and Dr. J. W. Rae, Toledo.—News Clipping.

Fifth District

Ashtabula County Medical Society met at the Hotel Ashtabula, Tuesday evening, October 8. Dr. C. W. Burhans, Cleveland, spoke on "Prophylactic Care of Infants and Children".—News Clipping.

Cuyahoga County—The Academy of Medicine of Cleveland presented the following programs during November:

November 1—Clinical and Pathological Section at Lutheran Hospital. "Injection Treatment of Hernia", by Dr. C. E. Ward; "Coagulation of the Gasserian Ganglion", by Dr. S. C. Lind; "Compound Fracture of the Femur", by Dr. Walter Stern; "Osteomyelitis of the Maxilla", by Dr. D. S. Spreng; "Roentgenologic and Pathologic Aspects of the Monosteitic forms of Paget's Disease", by Dr. Jean Groh and Dr. M. Simon; "Acute Isolated Myocarditis (Fiedler's Myocarditis)", by Dr. H. R. Sunkle and Dr. M. Simon.

November 6—Military Medicine Section, Medical Library Auditorium. "The Employment of the Medical Profession in Time of a National Emergency", by Surgeon General Charles R. Reynolds.

November 8—Joint Meeting of the Experimental Medicine Section and Cleveland Section of the Society for Experimental Biology and Medicine, at Institute of Pathology. (Program arranged by the Cleveland Clinic) "On the Maintenance of Testes in Hypophysectomized Rats in Parabiosis", by Eugene Cutuly, Ph.D., D. Roy McCullagh, Ph.D., and Dr. William E. Lower; "Excess Urinary Prolan in Cases of Pituitary Tumor", by Dr. E. Perry McCullagh and W. K. Cuyler, M.A. "The Influence of Thyrotropic Hermone on Iodine Metabolism", by B. F. Stimmel, Ph.D., and D. Roy McCullagh, Ph.D. "A Peculiar Relationship between the Emission of Light in Various Parts of the Spectrum", by Otto Glasser, Ph.D., and I. E. Beasley; "Leucopenic Index as a Diagnostic Aid in Allergy", by Dr. I. M. Hinnant; "The Cause of the Microcytosis of Pypochromic Anemia", by Dr. Russell L. Haden; "Experimental Studies on the Relation of Vitamin B to the Tone of the Large Intestine", by Dr. M. I. Sparks and Dr. E. N. Collins.

November 15—Regular Academy Meeting at Medical Library Auditorium. "Rheumatic Fever", by Dr. Homer E. Swift, Rockefeller Institute for Medical Research, New York.

Sixth District

Portage County Medical Society met at the Robinson Memorial Hospital, Ravenna, Thursday evening, November 7. Dr. George O'Malley, chief surgeon, Cleveland Police Department, was the speaker.—E. J. Widdecombe, M.D., Secretary.

Seventh District

Columbiana County Medical Society held a meeting at the Elks Home, Salem, Thursday, October 24. Dr. Louis Mark, Columbus, spoke on "Silicosis".—News Clipping.

Eighth District

Athens County Medical Society was addressed by Dr. C. H. Benson, Columbus, on the subject of "Tuberculosis", at a meeting held at the First Methodist Church, Athens, Tuesday, November 5.—T. A. Copeland, M.D., Secretary.

Guernsey County Medical Society held its regular semi-monthly luncheon meeting at the Ber-

wick Hotel, Cambridge, Thursday, October 17. Dr. George F. Swan, gave a report on the recent annual meeting of the State Association.—News Clipping.

Licking County Medical Society met at the Warden Hotel, Newark, Thursday evening, October 25. Dr. Beulah Cushman, Chicago, discussed "Headaches".—News Clipping.

Muskingum County Academy of Medicine met at the Hotel Rogge, Zanesville, Wednesday evening, November 6. Dr. Martin H. Fischer, Cincinnati, was the guest speaker.—Beatrice T. Hagen, M.D., Secretary.

Scioto County—The Hempstead Academy of Medicine held a meeting Monday evening, November 11. "Allergy" was discussed by Dr. Carlyle Thompson, Gallipolis, and Dr. M. A. Martin, Gallipolis, spoke on "Diagnosis and Treatment of Lateral Sinus Thrombosis".—Wm. E. Scaggs, M.D., Secretary.

Tenth District

Delaware County Medical Society entertained the members of the *Union County Medical Society* and the dentists of Delaware at a dinner meeting at the Jane M. Case hospital, Delaware, Tuesday evening, October 15. Dr. Richard Foregger, president of the Foregger Corporation, New York, was the speaker.—News Clipping.

Franklin County—The Columbus Academy of Medicine held the following meetings during November:

November 4—"Recent Advances in the Diagnosis and Treatment of Obliterative Arterial Diseases of the Extremities", by Dr. Louis G. Herrman, College of Medicine, University of Cincinnati.

November 11—"Malignant Hypertension", by Dr. George Crile, Cleveland.

November 18—"The Inheritance of Mental Defects", by Dr. A. T. Hopwood, Orient. "Epilepsy", by Dr. Serge Androp, Ohio Hospital for Epileptics, Gallipolis.

November 25—General Practitioners' Section, Address by the retiring chairman, Dr. C. H. Wells.—Bulletin.

Morrow County Medical Society held its regular meeting at the Globe Hotel, Mt. Gilead, Tuesday, November 5, with the dentists of the county as guests. Dr. F. C. Anderson, superintendent of the state sanatorium at Mt. Vernon spoke on "The Treatment of Pulmonary Diseases".—T. Caris, M.D., Secretary.

Ross County Medical Society held a dinner meeting at Chillicothe, Thursday, November 7. Dr. Parke G. Smith, Cincinnati, read a paper on "Tuberculosis of the Kidney". Dr. C. C. Sherburne, Columbus, newly elected Councilor for the Tenth District, spoke on organization matters.

Tribute Paid to Dr. Goodman

At the regular meeting of the Columbus Academy of Medicine, October 7, the following motion and tribute to Dr. S. J. Goodman, Columbus and former Councilor, was passed unanimously:

"That the Academy give Dr. S. J. Goodman a vote of thanks for his long and excellent term of service as Councilor of the Tenth District of the Ohio State Medical Association".

Dr. Goodman retired from the Council at the 1935 Annual Meeting, after having represented the Tenth District for 15 years. He was succeeded by Dr. C. C. Sherburne, Columbus.

—OSMJ—

Many Ohio Physicians Open New Offices or Change Locations

Among Ohio physicians who have recently opened offices or changed locations are: Dr. Charles Hollington, *West Mansfield;* Dr. A. J. Knapp, *East Liverpool;* Dr. P. H. Schmiedicke, *Napoleon;* Dr. Wells T. McCann, *New Lexington;* Dr. David Allen, *Dover;* Dr. W. S. Hamilton, *Norwood;* Dr. Paul J. Niederkorn, *Versailles;* Dr. William L. Hann, *Chattanooga;* Dr. J. W. Tirey, *Anna;* Dr. Richard Wenrick, *Winchester;* Dr. E. L. Montgomery, *Circleville;* Dr. Edwin Riemenschneider, *Berea;* Dr. A. H. Wilke, *Cheviot;* Dr. Elliott A. Hilsinger, *Cheviot;* Dr. Charles H. Thompson, *West Mansfield;* Dr. Anthony Ruppersburg, Jr., *Columbus;* Dr. Carl J. Mahkinen, *Ashtabula;* Dr. W. D. Wise, *Orrville;* Dr. M. S. Huber, *Pemberville;* Dr. Timothy F. O'Connor, *Ashtabula;* Dr. L. C. Ziegler, *Salem;* Dr. Myron H. Steinberg, *Youngstown;* Dr. John A. McNamara, *Marion;* Drs. M. R. Schwartz, D. M. Traul, E. J. Snyder, E. J. Kraker and A. M. Weil, *Akron;* Dr. S. J. Smith, *Bowling Green;* Dr. Lawrence Goodman, *Findlay;* Dr. Leonard H. Harris, *Elyria;* Dr. J. Frederick Doyle, *South Vienna;* Dr. David H. Levy, *Youngstown;* Dr. L. P. Cassidy, *Fultonham;* Dr. H. M. Amstutz, *Lancaster;* Dr. H. F. Vaughan, *Pioneer;* Dr. William L. Mahaffey, *Fredericktown;* Dr. Paul Grove, *Newark;* Dr. W. E. Savage, *Lynchburg;* Drs. R. E. Shell and H. E. Wilkinson, *Van Wert;* Dr. C. O. Butner, *Shiloh;* Dr. John M. Kidd, *Galion;* Dr. W. C. Rowler, *Rushville;* Dr. John Schafer, *Martins Ferry,* and Dr. Philmour M. Bein, *Mansfield.*

—OSMJ—

Cincinnati—Annual report of the Cancer Control Council for 1934-35, recently submitted by Dr. Carl A. Wilzbach, secretary, disclosed that the death rate from cancer in Cincinnati was not excessively high when compared to 13 other American cities comparable in size to Cincinnati. The number of deaths from cancer in 1932 was 681, in 1933, 676 and 1934, 712.

DEATHS IN OHIO

Nelson H. Amidon, M.D., Painesville; Western Reserve University School of Medicine, 1884; aged 76; died October 13. Dr. Amidon practiced in Painesville for 50 years. He was a member of the Masonic, Elks and Maccabee lodges. Surviving are his widow, three daughters and a son.

William N. Bailey, M.D., East Liverpool; Miami Medical College, Cincinnati, 1878; aged 85; former member of the Ohio State Medical Association and former Fellow of the American Medical Association; died October 10. He was the dean of the medical profession in Columbiana County, having practiced there for 57 years, and was prominent in civic affairs, having served on the board of trustees of the public library and the City Hospital. His nephew, Dr. C. H. Bailey, East Liverpool, survives.

Charles E. Bennett, M.D., Wauseon; Detroit Medical College, 1876; former member of the Ohio State Medical Association and the American Medical Association; aged 80; died October 28. Dr. Bennett followed his father, the late Dr. J. H. Bennett, in the medical profession and served his community for 59 years. He was a member of the Masonic and K. of P. lodges and the Congregational Church. A daughter survives him.

Charles H. Corwin, M.D., Lebanon, Medical College of Ohio, Cincinnati, 1901; aged 58; died November 8, following a heart attack. Dr. Corwin retired from active practice some time ago, and in recent years represented pharmaceutical concerns. He is survived by his widow and a sister.

Emma Ernsberger, M.D., Cairo; Laura Memorial Women's Medical College, Cincinnati, 1897; former member of the Ohio State Medical Association and the American Medical Association; aged 73; died October 11, from cancer. Dr. Ernsberger, for 14 years a medical missionary in Korea, was prominent in religious and social circles. She practiced medicine in Lima from 1920 to 1928, when failing health caused her retirement. Surviving are three sisters and a brother.

Ward Irving Huber, M.D., Cleveland; Western Reserve University, School of Medicine, Cleveland, 1912; aged 51; died October 3, of diabetes. Dr. Huber was head of the East Cleveland Clinic. He is survived by his widow, two sons, two brothers and two sisters.

O. E. McHenry, M.D., Blue Creek; Medical College of Ohio, Cincinnati, 1903; aged 68; member of the Ohio State Medical Association and the American Medical Association; died October 26. Dr. McHenry practiced in Blue Creek for 32 years, and was widely known for his active interest in community affairs. He was a member of the Moore's Chapel Church and the Masonic lodge. Surviving are his widow, two daughters, four brothers and a sister.

Joshua Giddings Lewis, M.D., Cleveland; Western Reserve University School of Medicine, 1866; aged 91, died October 15. Dr. Lewis retired 20 years ago, after having practiced in Cleveland for 50 years. He is survived by his widow, four daughters and a son.

Fred W. Murrey, M.D., Caldwell; Keokuk Medical College of Physicians and Surgeons, Iowa, 1900; aged 62, died September 15, following a two weeks' illness. Dr. Murrey practiced in Kansas, later in Stafford, Summerfield, New Concord, Cumberland and Caldwell. At the time of his death he was president of the Caldwell Board of Education and superintendent of the Sunday School of the Methodist Church. Surviving are his widow, five sons, two daughters, four brothers and a sister.

O. Curtis Ricksecker, M.D., Wilmot; Ohio Medical University, Columbus, 1897; aged 61; member of the Ohio State Medical Association and Fellow of the American Medical Association; died October 22, following a stroke of apoplexy. Dr. Ricksecker was a life-long resident of Wilmot. He served a number of years as health commissioner of Stark County, and was a past-president of the Stark County Medical Society. Dr. Ricksecker was a member of the Masonic Order and the Methodist Church. Surviving are his widow, three half-brothers, and two half-sisters.

O. H. Thomas, M.D., Fremont; Medical College of Ohio, Cincinnati, 1882; aged 76; former member of the Ohio State Medical Association and the American Medical Association; died October 19. Dr. Thomas was prominent in professional and civic affairs in Fremont until the beginning of his illness 18 months ago. He was health comsissioner of Sandusky County for 11 years. His widow survives.

John S. Tanner, M.D., Warren; Ohio State University College of Medicine, 1923; aged 52; died October 22, of complications. Surviving are his widow, two brothers and a sister.

Ella Welch, M.D., Ashley; Toledo Medical College, 1894; aged 72; former member of the Ohio State Medical Association and the American Medical Association; died September 24, following a heart attack. Dr. Welch had been a member of the Delaware County Board of Health since it was organized 15 years ago, and had practiced in Ashley for 41 years. She was a charter member of the Order of Eastern Star. Surviving are a son, two sisters, and a half-brother.

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NEWS NOTES *of* OHIO

Middletown—The late Mrs. Laura C. Iseminger left a bequest of $10,000 to the Middletown General Hospital.

Dayton—Dr. F. L. Shively was re-elected a member of the School Board for four years at the recent election.

Cleveland—Among the scientific exhibits at the recent meeting of the Inter-State Post Graduate Medical Association of North America held in Detroit, Dr. Myron Metzenbaum of Cleveland had an exhibit entitled "The Anatomic Replacement of the Dislocated Septal Cartilage in Young Children", which was illustrated by a series of anatomical specimens, photographs, plaster and rubber models and a mechanical model demonstrating how the dislocation of the lower end of the septal cartilage results in asymmetry of the nares.

Cleveland—Dr. Marion Douglass was one of the speakers at the recent annual meeting of the American Association of Obstetricians, Gynecologists and Abdominal Surgeons, at Skytop, Pa.

Cincinnati—Dr. J. J. Sutter, former Bluffton physician and later Allen County health commissioner, recently was named treasurer of the Eclectic Medical College here.

Cleveland—Dr. Daniel P. Quiring, professor of anatomy, Western Reserve University, School of Medicine and Mr. Arthur B. Fuller, chief preparator of the Cleveland Museum of Natural History, recently sailed for British East Africa where they will spend six months in mammal collecting and scientific research. Dr. and Mrs. George W. Crile, Cleveland, will join them late in November. The expedition is being sponsored by the Cleveland Clinic Foundation and the Cleveland Museum of Natural History.

Girard—Friends and associates of Dr. J. F. Nagle recently held a testimonial dinner in his honor at the Mahoning Valley Country Club. Dr. Nagle is leaving Girard to take post-graduate work at Johns-Hopkins hospital, Baltimore, Md.

Carrollton—Dr. C. R. Ziegler has completed his 52nd year in the practice of medicine. Dr. Ziegler first practiced in Chatfield, Crawford county in 1883, moving to Carrollton in 1885, where he is still active in his profession.

McArthur—Dr. O. S. Cox, veteran Vinton County physician, fractured his right hip in a fall at his home October 22. He has been a patient at the Cherrington Hospital, Logan.

Alliance—Dr. George L. King, Jr., discussed "Eyes and the School" at the annual convention of the Northeastern Ohio Teachers' Association recently held at Cleveland.

Cincinnati—Dr. Charles A. Neal has been elected first vice-president of the Ohio Welfare Conference.

Orient—In a recent address before the Ohio Welfare conference, Dr. C. C. Kirk, superintendent of the Ohio Institution for Feeble Minded, pointed out the urgent need for legislation in Ohio permitting voluntary sterilization of inmates of public institutions.

Dayton—Announcement has been made of the recent marriage of Dr. Herbert L. Brumbaugh and Miss Sara Isabelle Ross.

Columbus—Dr. R. R. Harris, who last year was appointed chief medical officer, U. S. Veteran's Administration, Cincinnati, has been promoted to the rank of Colonel, Medical Reserve Corps, U. S. Army.

Zanesville—Dr. Anne D. Marting, Ironton, president of the Ohio Federation of Business and Professional Women's Clubs, recently addressed a dinner meeting of the Zanesville Business and Professional Women's club on "Mystery, Magic and Medicine".

Findlay—Mrs. J. C. Tritch, wife of Dr. J. C. Tritch, and leader in the American Red Cross, and the Home and Hospital Association of Findlay, died recently.

CLASSIFIED ADVERTISEMENTS

Rates for advertisements under this heading are 50 cents per line, payable in advance. Minimum charge of $1.00 for each insertion. Price covers the cost of remailing answers. Forms close 16th of the month preceding publication.

WANTED—Young physician for assistant. Write qualifications. M. H. Castle, M.D., 1500 Medical Arts Building, Cleveland, Ohio.

FOR RENT—Office of deceased physician, ten years' general practice. Available at once. No real estate. References exchanged. Write Mrs. F. G. Smith, 320 Main Street, Hamilton, Ohio.

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OBSTETRICS—Informal Course; Intensive Course Two Weeks starting February 3, 1936; Laboratory Course.

FRACTURES & TRAUMATIC SURGERY—Informal Practical Course; Intensive Course Ten Days starting January 13, 1936.

PEDIATRICS—Informal Course; Personal Courses.

EAR, NOSE & THROAT—Informal Course; Intensive Course Two Weeks starting April 6, 1936.

UROLOGY—General Course Two Months; Intensive Course Two Weeks; Special Courses.

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Well-Attended Eighth District Meeting Held at Marietta

Approximately 100 physicians attended the Fall meeting of the Eighth District of the Ohio State Medical Association at Marietta, October 24.

The program was arranged by Dr. A. Howard Smith and Dr. J. B. Penrose, Marietta, president and secretary respectively of the Eighth District. Dr. Wm. W. Sauer and Dr. R. M. Meredith, Marietta, were in charge of local arrangements.

Following a luncheon, Dr. Stephen A. Cunningham, Marietta, welcomed the visiting physicians and urged them to maintain an active interest in all the activities of organized medicine.

Dr. E. R. Brush, Zanesville, councilor for the Eighth District, spoke about the value of district meetings, and expressed the hope that more members would make use of the facilities and services offered by the State Association.

Some of the more important legislative and social-economic problems confronting the medical profession in Ohio were discussed briefly by Charles S. Nelson, Columbus, Executive Secretary, Ohio State Medical Association. He explained the functions of the State Headquarters Office and its services to members, urged a more general participation by all members in the affairs of the county societies and the State Association.

The scientific program consisted of an address on "Congestive Heart Failure, Its Mechanism and Treatment", by Dr. G. I. Nelson, Columbus, and "Some Significant Diagnostic Data from a Urologic Standpoint", discussed by Dr. O. D. Barker, Parkersburg, W. Va.

—OSMJ—

State Institution Physicians Hold Session at Athens

Fiftieth Annual Meeting of the Association of Physicians of the Ohio State Institutions was held at Athens, October 17 and 18.

Dr. A. T. Hopwood, Orient, president of the association, presided at the opening session, at which Dr. C. H. Creed, superintendent of the Athens State Hospital, gave an address of welcome, and reports were made by the secretary-treasurer, Dr. H. M. Turk, Lima, and the executive and legislative committees. Papers on various phases of mental and nervous diseases were presented by Dr. Beatrice Postle, Columbus; Dr. Serge Androp, Gallipolis; Dr. Earl Crofts, Lima; Dr. R. M. Kingsbury, Cleveland, and Dr. Guy H. Williams, Jr., Cleveland.

At the session on October 18, Dr. Turk was elected president of the association, and Dr. Postle, secretary-treasurer for the ensuing year. Scientific papers were presented by Dr. M. N. Fowler, Athens; Dr. N. W. Kaiser, Toledo; Dr. George W. Kisler, Dr. J. F. Bateman and Dr. Esther B. Tietz, Cincinnati, Dr. H. R. Campbell, Dayton and Dr. Hopwood.

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IN a recent study of fat metabolism in infants, Holt, Tidwell and Kirk* report that olive oil showed the highest percent retention (95.1%) of all fats studied but one, olein (97.5%). These authors found the fat of SIMILAC (which is 20% olive oil) showed a better percent retention (92.6%) than butter fat (88.9%)—and as high a retention as breast milk fat (92.4%).

To quote these authors—"the differences in fat retention on these various fats as shown on normal infants are not great; for the normal infant it is probably immaterial whether he absorbs 85% or 95% of his fat intake. It seemed possible, however, that *in subjects who have difficulty in fat assimilation, such as premature infants, the observed small differences might become large differences. A few observations made on premature infants and twins have borne this out*—."

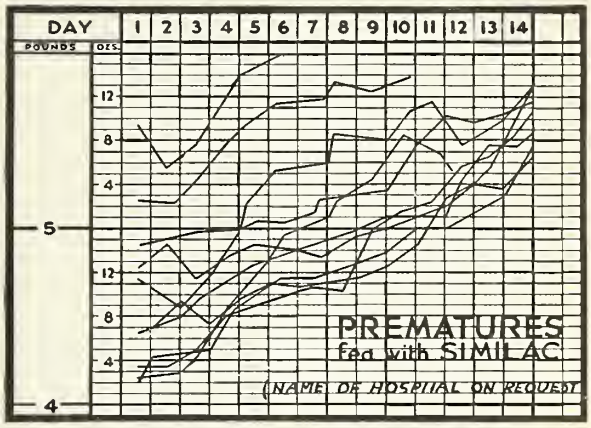
The observations referred to covered only three prematures fed on different fats, but showed an average of 78.4% retention for olive oil as compared to only 52.5% retention for butter fat.

*Holt, Tidwell and Kirk, Studies on Fat Metabolism in Infants—Acta Pediatrica. Vol. XVI, 1933.

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has given noticeably good results in feeding the premature infant. One of the reasons lies, as here pointed out, in the composition of its fat. Another reason is its consistently zero curd tension. The finer the curd the greater the surface area. The greater the surface area the more exposed are the fats, carbohydrates, proteins and salts to the digestive enzymes. Result . . . the food substances are more quickly and readily utilized.

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Rules on Giving Hospital News to Newspapers Are Adopted

An attempt to solve the problem of how much information hospitals should give newspapers concerning accident cases has been made in Cleveland through a procedure in such cases, agreed upon by The Cleveland Academy of Medicine and the Cleveland Hospital Council, and approved by the newspapers, according to a recent issue of the *Ohio Hospital News*.

The method used by Cleveland hospitals in making available information relative to patients injured by accident follows:

Responsibility for providing information relative to patients should be placed on one individual to whom all inquiries should be directed.

Items of public information as shown below may be given without the patient's consent:

FOR BOTH POLICE AND OTHER CASES

1. Name:
   - a. Married or single
   - b. Color
   - c. Sex
   - d. Age
   - e. Occupation
   - f. Firm or company employing patient
   - g. Address
2. Nature of the Accident:
   - a. Injured by automobile, explosion, shooting, etc.
   - b. If there is a fracture, it is not to be described in any way except to state the member involved, i.e., leg, arm, etc.
   - c. More than a statement that it is simple or compound may not be made.
3. Injuries of the Head:
   - a. Simply a statement that the injuries are of the head may be made.
   - b. It may not be stated that the skull is fractured.
   - c. No opinion as to the severity of the injury may be given except that, in police cases, opinion may be given when condition is definitely determined.
   - d. Prognosis is not to be made.
4. Internal Injuries:
   - a. It may be stated that there are internal injuries but nothing more specific as to the location of the injuries.
   - b. A statement that the condition is very serious may be made.
5. Unconsciousness:
   - a. If the patient is unconscious when he is brought to the hospital, a statement of this fact may be made.
   - b. The cause of unconsciousness, however, should not be given.
6. Intoxication:
   - a. No statement may be made as to whether the patient is intoxicated or otherwise.
7. Burns:
   - a. Statement may be made that patient is burned, also member of body involved, i.e., chest, face, hand, etc.
   - b. Statement as to how accident occurred must be made only when the absolute facts are known.
8. Hospitals may state to the representatives of newspapers, the name of the attending physician of private patients and refer such representatives to the physician for information about the case, but, in other than police cases, the newspapers shall not use the name of the physician without his sanction.
9. When newspapers request the privilege of photographing a patient in the hospital, such permission will only be given:
   - a. If in the opinion of the doctor in charge of the case, the patient's condition will not be jeopardized.
   - b. If the patient (or in the case of a minor, the parents or guardian) are willing to have photograph taken.

FOR POLICE CASES ONLY

1. Cases of Poisoning:
   - a. No statement is to be made that a patient is poisoned.
   - b. No information as to kind of poisonous substance, such as mercuric chloride, phenol, carbon monoxide, etc., may be given.
   - c. No statement concerning motive, whether accidental or suicidal, etc., may be given.
2. Shooting:
   - a. A statement may be made that there is a penetrating wound.
   - b. No statement may be made as to how the accident occurred, i.e., accidental, suicidal, homicidal, in a brawl, nor the environment under which the accident occurred.
3. Stabbing:
   Same general statement may be made for Stabbing as for Shooting accidents.

OFFICIAL REGISTRIES FOR NURSES

May we call to the attention of physicians the official registries maintained by Districts of the Ohio State Nurses' Association for the benefit of physicians, hospital, and the public? These registries are operated not for profit and are located in the following cities:

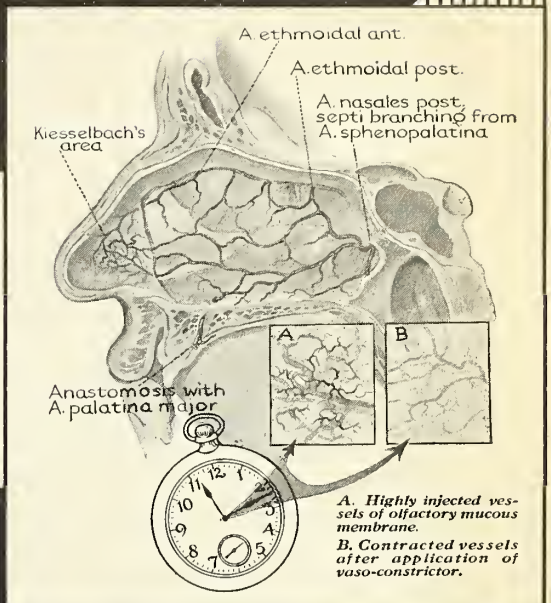
	Telephone:
42 Hawthorne Ave., Akron	Fr. 7013
1316 Mahoning Bank Bldg., Youngstown	44581
2157 Euclid Ave., Cleveland	Prospect 1951
199 Olney Ave., Marion	Telephone 2118
2651 Gilbert Ave., Apt. No. 3, Cincinnati	Wodburn 7127
2352 Monroe Street, Toledo	Main 7962
The Arcade, Ludlow St., Dayton	Fulton 7211
435 E. Liberty St., Springfield	M. 191
Normandie Hotel, Columbus	ADams 1569
General Hospital, Portsmouth	559

The Ohio State Nurses' Association also operates an employment bureau where nurses may be secured for physicians' and dentists' offices, hospitals, public health nursing organizations, official health organizations, etc.

OHIO STATE NURSES' ASSOCIATION, 50 East Broad Street, Columbus, Ohio

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Action more sustained than that of epinephrine
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Neo-Synephrin Hydrochloride Solution ¼% and 1%—1 oz., 4 oz.

Neo-Synephrin Hydrochloride Emulsion, Aromatic ¼%—1 oz., 1 pt.

Neo-Synephrin Hydrochloride Jelly ½%—⅝ oz. collapsible tube

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Blake New Industrial Commissioner

Will T. Blake, East Liverpool, has been appointed a member of the State Industrial Commission, succeeding the late William M. Morgan, Newark.

Mr. Blake was endorsed by the State Federation of Labor. He has been editor of the journal of the *Brotherhood of Operative Potters* for many years, and served as Director of Industrial Relations during the administration of Governor Myers Y. Cooper.

—OSMJ—

Ohioans Address R. R. Surgeons

Approximately 500 physicians and guests attended the twelfth annual convention of the Association of New York Central Lines Surgeons held in Columbus, October 30 and 31.

The program committee, under the chairmanship of Dr. Sterling B. Taylor, Columbus, provided a splendid program of clinics and lectures.

Ohio physicians who took part in the clinical sessions and scientific discussions were Dr. I. B. Harris, Dr. J. D. Wilson, Dr. J. M. Dunn, Dr. Henry Schwarzell, Dr. Hugh A. Baldwin, Dr. A. M. Steinfeld, Dr. H. P. Worstell, Dr. D. M. Johnson, Dr. Arthur M. Hauer, Dr. R. C. Obetz, Dr. E. H. Wilson, Dr. E. J. Stedem, Dr. Carl Hoy, Dr. George Harding, Dr. F. E. Pierce, of Columbus; Dr. C. F. Nelson and Dr. N. C. Yarian, Cleveland, and Dr. J. U. Buchanan, Youngstown.

The following officers were elected for the ensuing year: Dr. Walter H. McNeill, Jr., New York, president; Dr. Geo. P. Myers, Detroit, Mich., Dr. H. A. Baldwin, Columbus, Dr. R. W. Cotton, McKees Rocks, Pa., and Dr. E. P. Hayden, Boston, Mass., vice-presidents, and Mr. H. A. Fathauer, Chicago, Ill., secretary-treasurer.

—OSMJ—

Health Commissioners Meet

Sixteenth Annual Conference of Ohio Health Commissioners was held at the Deshler-Wallick Hotel, Columbus, November 13, 14 and 15.

Among the subjects discussed were public health nursing; maternal and child health; what a health commissioner can do with vital statistics; scarlet fever; Ohio Government Survey's report on the Department of Health; diphtheria; and tuberculosis.

A more detailed account of the meeting will appear in the January issue of *The Journal.*

—OSMJ—

William J. Burns, Detroit, executive secretary of the Wayne County Medical Society since 1930, has been named to a similar position with the Michigan State Medical Society. Mr. Burns was executive secretary of the Academy of Medicine of Toledo and Lucas County previous to 1930.

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For example, many may have wondered—but, certainly, few have inquired—as to the origin of the popular designation for tin containers. The name "tin cans" arose from an abbreviation of the term "tin cannisters" applied to them during the latter part of the last century by English manufacturers. Such a name is hardly correct, since "tin cans" are made from mild steel which has been rolled into thin sheets and coated with pure tin. Actually, the can is about ninety-eight percent iron.

Again, interest has sometimes been expressed in regard to the nature and purpose of the enamels found in cans in which certain products are packed. These enamels are essentially lacquers developed by years of intensive research; they are baked on the tin surface at high temperatures. Their chief purpose is to preserve natural flavor and color characteristics of some foods. While desirable in certain instances, enameled cans are not necessary to insure a wholesome canned product.

The facts about the foods contained in cans are equally simple. Canned foods are merely selected foods which, after preparatory operations, are hermetically sealed in tin containers from which most of the air has been excluded. The preservation of the foods is then effected by a heat treatment.

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(1) 1934. Ind. Eng. Chem. 26, 758
(2) 1932. Ind. Eng. Chem. 24, 650

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New Books

National Medical Monographs, edited by Morris Fishbein, M.D., and published by the National Medical Book Company, Inc., 119 West 41st St., New York City. Through an error in the original announcement of the publishers, the price of these books was listed in the August issue of *The Journal* at $4.00 per volume, instead of $3.00.

Pediatric Treatment, by Philip S. Potter, A.B., M.D., F.A.A.P., formerly instructor in Clinical Pediatrics, Medical School, Syracuse University; chief of the Pediatric Service, Berkeley Health Center. A manual of the treatment of the diseases of infants and children designed as a reference work especially for the general practitioner and physician entering the field of pediatrics. Price $5.00. The MacMillan Company, 60 Fifth Ave., New York, publishers.

Diseases of the Nose and Throat, by Charles J. Imperatori, M.D., F.A.C.S., Professor of Clinical Otolaryngology, and Herman J. Burman, M.D., Instructor of Clinical Otolaryngology, New York Post-Graduate Medical School, Columbia University, New York. A text-book with 480 illustrations for general practitioners and medical students, with a comprehensive description of the diseases most frequently encountered. Price $7.00. J. P. Lippincott Company, Philadelphia, Pa., publishers.

Individual Exercises, by George T. Stafford, M.S., Director of Corrective Physical Education, University of Illinois; Harry B. DeCook, M.A., Director of Corrective Physical Education, Northwestern University; Joseph L. Picard, M.S., Director of Corrective Physical Education, University of Arizona. Selected exercises for individual conditions. 100 illustrations. Price $1.00. A. S. Barnes & Co., 67 West 44th St., New York.

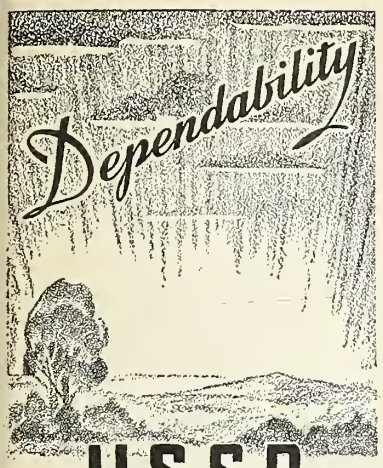
Free Medical Care, by E. C. Buehler, Director of Forensics, University of Kansas. Contains 360 pages of material by outstanding authorities in the medical and social field on both sides of the question of socialized medicine. Published primarily for the use of debate teams. Price $2.00. Noble and Noble, Publishers, Inc., 100 Fifth Ave., New York.

Prescription Writing and Formulary. The Art of Prescribing. By Charles Solomon, M.D., Assistant Clinical Professor of Medicine, Long Island College of Medicine; associate attending physician and chief of the Medical Clinic, Jewish Hospital of Brooklyn; lecturer in materia medica, Nurses Training School, Jewish Hospital. Price $4.00. J. B. Lippincott Company, Philadelphia, Pa., Publishers.

Dr. Colwell's Daily Log for Physicians. A compact financial record system, containing forms for daily pages, monthly business summary, expenses, appointments, surgical records, etc. Price $6.00. Colwell Publishing Co., Champaign, Ill., Publishers.

Tumors of the Urinary Bladder. By Edwin



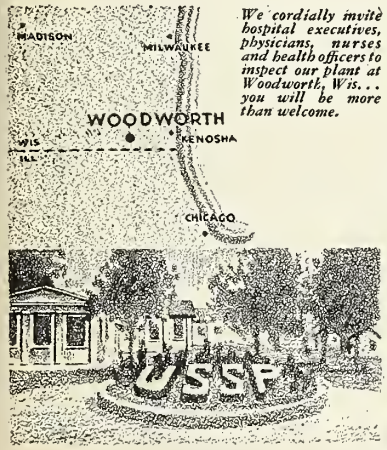


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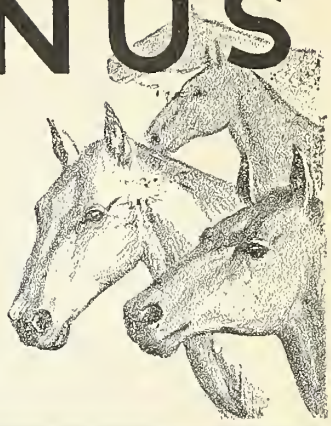
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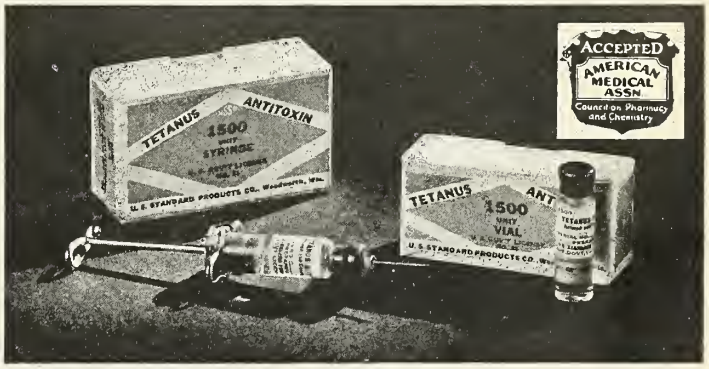
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Handbook of Physiology, by the late W. D. Halliburton, M.D., LL.D., F.R.C.P., F.R.S., formerly Professor of Physiology, University of London, King's College and R. J. S. McDowell, M.B., D.Sc., F.R.C.P. (Edin), Professor of Physiology, University of London, King's College, author of "The Science of Signs and Symptoms", 34th edition, with numerous illustrations in the text, many of which are colored, and four colored plates. Price $5.50. P. Blakiston's Son & Co., Inc., 1012 Walnut St., Philadelphia, publishers.

Do's and Don'ts for Health, Happiness and Abundant Life, by John J. Sutter, M.D., Allen County Health Commissioner, Lima, Ohio. The Bluffton News Printing and Publishing Co., Bluffton, Ohio, publishers. Price $1.00.

—OSMJ—

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A small pamphlet containing a list of the apparatus accepted by the Council on Physical Therapy, of the American Medical Association, the first one published under the direction and supervision of the Council, is just off the press. In addition to the list and description of accepted apparatus, the pamphlet contains indications for the use of each type and a statement relative to efficacies and dangers.

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—OSMJ—

Columbus—Dr. J. H. J. Upham spoke before the West Virginia Educational Conference at Charleston, W. Va., October 24, on "Modern Trends in Medical Practice".

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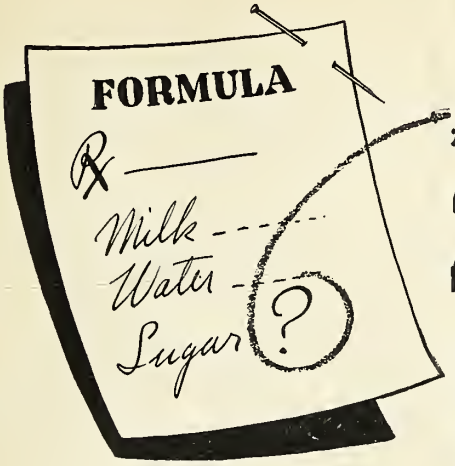
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